

AMENDED IN SENATE MARCH 14, 2011

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL

No. 97

Introduced by Committee on Budget (Blumenfield (Chair), Alejo, Allen, Brownley, Buchanan, Butler, Cedillo, Chesbro, Dickinson, Feuer, Gordon, Huffman, Mitchell, Monning, and Swanson)

January 10, 2011

~~An act relating to the Budget Act of 2011.~~ *An act to amend Section 76000.5 of the Government Code, to amend Section 1797.98a of the Health and Safety Code, to amend Sections 12693.43, 12693.60, 12693.615, and 12693.65 of the Insurance Code, to amend Sections 12009, 12201, 12204, 12207, 12242, 12251, 12253, 12254, 12257, 12258, 12260, 12301, 12302, 12303, 12304, 12305, 12307, 12412, 12413, 12421, 12422, 12423, 12427, 12428, 12429, 12431, 12433, 12434, 12491, 12493, 12494, 12601, 12602, 12631, 12632, 12636, 12636.5, 12679, 12681, 12801, 12951, 12977, 12983, 12984, and 13108 of the Revenue and Taxation Code, to amend Sections 42007, 42007.3, 42007.4, and 42008.7 of the Vehicle Code, and to amend Sections 4474.5, 14007.9, 14091.3, 14105.31, 14105.33, 14105.332, 14105.34, 14126.033, 14132, 14154, and 14301.11 of, to amend and repeal Sections 14105.191 and 14134.1 of, to amend, repeal, and add Section 14134 of, to add Sections 14105.07, 14105.192, 14105.451, 14126.036, 14131.05, and 14131.07 to, and to add Article 6 (commencing with Section 14589) to Chapter 8.7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to health care services, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

AB 97, as amended, Committee on Budget. ~~Budget Act of 2011.~~
Health care services.

(1) Existing law authorizes each county to establish a Maddy Emergency Medical Services (EMS) Fund for reimbursement of EMS-related costs, as specified, and provides for the deposit into the EMS Fund of an additional penalty that the county board of supervisors is authorized to have levied in the amount of \$2 for every \$10, or part of \$10, upon fines, penalties, and forfeitures collected for criminal offenses, as specified.

Existing law establishes a one-time amnesty program for fines and bail meeting certain requirements between January 1, 2012, and June 30, 2012. Existing law includes the above-described additional penalty within this amnesty program.

This bill would, until July 1, 2016, require the levy of the additional \$2 for every \$10 of a penalty and require the deposit of these moneys into the continuously-appropriated State Emergency Services Fund, which would be established by the bill. This bill would continuously appropriate, on an annual basis, 15% of the moneys in the fund, not to exceed \$9 million, to the Emergency Medical Services Authority for allocation to local emergency medical services agencies in counties that had elected, prior to the effective date of this act, to levy the additional penalty for the purpose of maintaining pediatric trauma and emergency services. The bill would make the remainder available, upon appropriation, to the State Department of Health Care Services for the nonfederal share of Medi-Cal program expenditures related to emergency medical services. This bill would also exempt this additional penalty from the one-time amnesty program.

By increasing the duties of local officials, this bill would impose a state-mandated local program.

(2) Existing law creates the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health, vision, and dental benefits to children less than 19 years of age who meet certain criteria, including having a limited household income. Existing law requires families with children participating in the program to pay specified family contribution amounts. Existing law continuously appropriates funds, including family contributions, to the board from the Healthy Families Fund for the program.

This bill would, commencing on a specified date, increase those family contribution amounts, subject to federal authorization and any lesser increase in family contribution as is authorized by the federal Department of Health and Human Services. By increasing moneys deposited into a continuously appropriated fund, the bill would make an appropriation.

Existing law requires the board to establish the required copayment levels for specific benefits and prohibits copayments from exceeding the copayment level established for state employees under the Public Employees' Retirement System (PERS) as of January 1, 1998, and from exceeding \$250 annually per family. Existing law also requires covered health benefits provided under the program to be equivalent to those provided to state employees under PERS as of January 1, 1998.

This bill would require the board to set copayments for outpatient emergency room and inpatient hospital services at specified amounts, contingent upon federal approval and implementation of the same copayments under Medi-Cal, as specified. The bill would also modify the health benefit and copayment provisions to prohibit copayments from exceeding those charged, and require covered health benefits to be equivalent to those provided, to state employees under PERS in the year prior to the program plan year, except as otherwise provided. The bill would deem regulations of the board to implement these provisions to be emergency regulations.

(3) Existing law provides, except as specified, that vision benefits under the Healthy Families Program shall be equivalent to, and subscriber copayment levels shall reflect, those provided to state employees through the Department of Personnel Administration on July 1, 1997.

This bill would delete the specified date of July 1, 1997, from these provisions.

(4) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing law imposes various taxes, including a tax at a specified rate on the gross premiums of an insurer, as defined, and, until July 1, 2011, on the total operating revenue, as specified, of a Medi-Cal managed care plan, as defined. Existing law continuously

appropriates the revenues derived from the tax on Medi-Cal managed care plans for specified purposes.

This bill would extend the imposition of the tax on the total operating revenue of Medi-Cal managed care plans until January 1, 2014, and make other conforming changes. By extending the imposition of a tax whose revenues are continuously appropriated, this bill would make an appropriation.

(5) Existing law requires the establishment of protocols to ensure appropriate services are provided for persons transitioning as a result of the planned closure of the Agnews Developmental Center and the Lanterman Developmental Center. For persons transitioning under a plan for the closure of these developmental centers who have service needs for coordinated medical and specialty care identified in their individual program plans that cannot be met using the traditional Medi-Cal fee-for-service system, existing law establishes a structure requiring provision of those services under Medi-Cal managed care health plans that are currently operational in prescribed counties as a county organized health system or a local initiative, if consumers choose to enroll, and authorizes prescribed supplemental payments, including payments for administrative services.

This bill would recast those provisions to require, for consumers transitioning from the Lanterman Developmental Center, that the Medi-Cal managed care health plan be any plan operating in the various counties if the consumers choose to enroll, or as mandated by prescribed statutory provisions; to delete consultation with the Lanterman Developmental Center staff as an administrative service eligible for supplemental reimbursement; and to require that plans be paid a full-risk capitation payment.

(6) Existing law requires the collection of a fee from a person who is ordered or permitted to attend a traffic violator school and requires revenues derived from the fee to be collected and deposited in the general fund of a county for distribution with \$2 for every \$10 that would have been collected as an additional penalty deposited in the EMS Fund.

This bill would require, on and after July 1, 2011, in every county, \$2 for every \$10 that would have been collected as an additional penalty to be deposited in the State Emergency Services Fund.

By increasing the duties of local officials, this bill would impose a state-mandated local program.

(7) Existing law, operative 30 days after the date that the increase in the state's federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) is no longer available, requires, no later than 90 days after this operative date, each individual to pay a monthly premium that is equal to 5% of his or her individual or spousal countable income, as described, except that the premium cannot fall below or exceed a specified minimum and maximum premium payment, as provided.

This bill would, instead, make these provisions operative 30 days after the execution of a declaration by the Director of Health Care Services that states that implementation of these provisions will not jeopardize the state's ability to receive certain federal funds, as specified.

(8) Existing law, until January 1, 2012, requires the State Department of Health Care Services, subject to any necessary federal approval, to take all appropriate steps to amend the Medicaid state plan, to implement a requirement that any hospital that does not have in effect a contract with a Medi-Cal managed health care plan that establishes payment amounts for services furnished to a beneficiary enrolled in that plan shall accept, as payment in full, prescribed payment amounts.

This bill would extend the duration of these provisions until January 1, 2013.

(9) Existing law, until July 31, 2012, requires that money appropriated for the purposes of the Medi-Cal Long-Term Care Reimbursement Act shall be, in part, used for increasing rates, except as otherwise provided, for freestanding nursing facilities, as specified. Existing law requires that the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purposes of these provisions shall not exceed a specified amount plus the projected cost of complying with new state and federal mandates. Existing law requires the weighted average Medi-Cal reimbursement rate increase for the 2010–11 and 2011–12 rate years to be adjusted by the department for specified reasons.

This bill would require, except as provided, that for dates of service on and after June 1, 2011, the payments resulting from the application of these rate increases shall be reduced by 10% and would authorize the Director of Health Care Services to adjust the percentage reductions as specified. This bill would require, except as provided, that payments to intermediate care facilities for the developmentally disabled, as specified, for dates of service on and after June 1, 2011, shall not exceed

the reimbursement rates that were applicable to those providers in the 2008–09 rate year, reduced by 10%. This bill would also authorize the Director of Health Care Services to adjust the percentage reductions as specified.

(10) Existing law requires, except as otherwise provided, Medi-Cal provider payments to be reduced by 1% or 5%, as specified, for dates of service on and after March 1, 2009. Existing law also requires provider payments for specified non-Medi-Cal programs to be reduced by 1% for dates of on and after March 1, 2009.

This bill would provide that these provisions shall become inoperative for dates of service on and after June 1, 2011. This bill would require, except as otherwise provided, that Medi-Cal and specified non-Medi-Cal provider payments be reduced by 10%, as prescribed, for dates of service on and after June 1, 2011.

(11) Existing law requires the reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs, as defined, to consist of the estimated acquisition cost of the drug, as defined, plus a professional fee for dispensing. Existing law authorizes the State Department of Health Care Services to enter into contracts with manufacturers of single-source and multiple-source drugs, on a bid or nonbid basis, for drugs from each major therapeutic category. Existing law requires, among other things, that contracts executed pursuant to these provisions provide for an equalization payment amount, as defined, to be remitted to the department by the manufacturer on a quarterly basis.

This bill would, instead, provide that the contracts shall provide for a state rebate, as defined, and would make conforming changes. This bill would also provide that it is the intent of the Legislature to enact legislation by August 1, 2011, that provides for the development of a new reimbursement methodology for pharmacy providers. This bill would, in relation to establishing the new reimbursement methodology, authorize the State Department of Health Care Services to require providers, manufacturers, and wholesalers to submit any data the Director of Health Care Services determines is necessary or useful in preparing for the transition from a methodology based on average wholesale price to a methodology based on actual acquisition price.

(12) Existing law requires Medi-Cal beneficiaries to make set copayments for specified services. Copayments for services, under existing law, do not reduce the reimbursement to the providers. Existing law, with certain exceptions, prohibits a provider from denying services

to an individual solely because the person is unable to pay the copayment.

This bill would, commencing as provided, revise the copayment rates, expand the services for which copayments are due, and require the department to reduce the amount of the payment to the provider by the amount of the copayment. The bill would provide that, with certain exceptions, a provider has no obligation to provide services to a beneficiary who does not pay the copayment at the point of service.

(13) Existing law, provides that outpatient services provided by a physician are a covered benefit under the Medi-Cal program, subject to utilization controls.

This bill would, to the extent permitted by federal law, limit physician office and clinic visits that are a covered benefit under the Medi-Cal program, with specified exceptions, to 7 visits per beneficiary per fiscal year. This bill would require these provisions to be implemented on the first day of the first calendar month following 180 days after the effective date of the bill or on the first day of the calendar month following 60 days after federal approval, whichever is later.

(14) Existing law provides for a schedule of benefits under the Medi-Cal program, which includes prescribed drugs subject to the Medi-Cal List of Contract Drugs, enteral formulae subject to the Medi-Cal list of enteral formulae, and hearing aids, all of which are subject to utilization controls. Existing law provides that nonlegend acetaminophen-containing products, with the exception of children's Tylenol, selected by the department are not covered benefits.

This bill would, in relation to these benefits, instead provide that nonlegend acetaminophen-containing products, with the exception of children's acetaminophen-containing products, and nonlegend cough and cold products, selected by the department are not covered benefits. This bill would, in relation to enteral formulae, instead refer to the benefit as enteral nutrition products. This bill would, except as specified, require that the purchase of enteral nutrition products be limited to those products administered through a feeding tube. This bill would also, with certain exceptions, establish an annual per beneficiary benefit cap amount, as defined, for optional hearing aid benefits.

(15) Existing law provides that it is the intent of the Legislature to provide appropriate funding to the counties for the effective administration of the Medi-Cal program, except for specified fiscal years in regard to any cost-of-doing-business adjustment.

This bill would additionally provide that it is the intent of the Legislature to not appropriate funds for the cost-of-doing-business adjustment for the 2011–12 fiscal year.

(16) Existing law, the Adult Day Health Medi-Cal Law, establishes adult day health care services as a Medi-Cal benefit for Medi-Cal beneficiaries who meet certain criteria.

This bill would provide, to the extent permitted by federal law, that notwithstanding existing law, adult day health care be excluded from coverage under the Medi-Cal program. This bill would provide that this provision shall be implemented on the first day of the first calendar month following 90 days after the effective date of the bill or on the first day of the first calendar month after federal approval, whichever is later.

(17) The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session for that purpose. Governor Schwarzenegger issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on December 6, 2010. Governor Brown issued a proclamation on January 20, 2011, declaring and reaffirming that a fiscal emergency exists and stating that his proclamation supersedes the earlier proclamation for purposes of that constitutional provision.

This bill would state that it addresses the fiscal emergency declared and reaffirmed by the Governor by proclamation issued on January 20, 2011, pursuant to the California Constitution.

(18) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

(19) This bill would declare that it is to take effect immediately as an urgency statute.

~~This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2011.~~

Vote: ~~majority~~^{2/3}. Appropriation: ~~no~~ yes. Fiscal committee: ~~no~~ yes. State-mandated local program: ~~no~~ yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 76000.5 of the Government Code is
2 amended to read:

3 76000.5. (a) (1) Except as otherwise provided in this section,
4 ~~for purposes of supporting emergency medical services pursuant~~
5 ~~to Chapter 2.5 (commencing with Section 1797.98a) of Division~~
6 ~~2.5 of the Health and Safety Code~~, in addition to the penalties set
7 forth in Section 76000, ~~the county board of supervisors may elect~~
8 ~~to levy on and after July 1, 2011~~, an additional penalty in the
9 amount of two dollars (\$2) for every ten dollars (\$10), or part of
10 ten dollars (\$10), *shall be levied* upon every fine, penalty, or
11 forfeiture imposed and collected by the courts for all criminal
12 offenses, including violations of Division 9 (commencing with
13 Section 23000) of the Business and Professions Code relating to
14 the control of alcoholic beverages, and all offenses involving a
15 violation of the Vehicle Code or a local ordinance adopted pursuant
16 to the Vehicle Code. This penalty shall be collected together with
17 and in the same manner as the amounts established by Section
18 1464 of the Penal Code.

19 (2) This additional penalty does not apply to the following:

20 (A) A restitution fine.

21 (B) A penalty authorized by Section 1464 of the Penal Code or
22 this chapter.

23 (C) A parking offense subject to Article 3 (commencing with
24 Section 40200) of Chapter 1 of Division 17 of the Vehicle Code.

25 (D) The state surcharge authorized by Section 1465.7 of the
26 Penal Code.

27 ~~(b) Funds shall be collected pursuant to subdivision (a) only if~~
28 ~~the county board of supervisors provides that the increased~~
29 ~~penalties do not offset or reduce the funding of other programs~~
30 ~~from other sources, but that these additional revenues result in~~
31 ~~increased funding to those programs.~~

32 ~~(e)~~

33 (b) Moneys collected pursuant to subdivision (a) shall be taken
34 from fines and forfeitures deposited with the county treasurer prior
35 to any division pursuant to Section 1463 of the Penal Code.

36 ~~(d) Funds collected pursuant to this section shall be deposited~~
37 ~~into the Maddy Emergency Medical Services (EMS) Fund~~

1 established pursuant to Section 1797.98a of the Health and Safety
2 Code.

3 ~~(e) This section shall remain in effect only until January 1, 2014,~~
4 ~~and as of that date is repealed, unless a later enacted statute, that~~
5 ~~is enacted before January 1, 2014, deletes or extends that date.~~

6 *(c) Moneys collected pursuant to this section shall be deposited*
7 *into the State Emergency Services Fund, which is hereby*
8 *established within the State Treasury. Notwithstanding Section*
9 *13340, 15 percent of the moneys deposited into the fund, not to*
10 *exceed nine million dollars (\$9,000,000), is hereby continuously*
11 *appropriated on an annual basis to the Emergency Medical*
12 *Services Authority for the allocation to local emergency medical*
13 *services agencies in counties that had elected, prior to the effective*
14 *date of the act that added this subdivision, to levy the additional*
15 *penalty in the amount of two dollars (\$2) for every ten dollars*
16 *(\$10), or part of ten dollars (\$10), upon every fine, penalty, or*
17 *forfeiture imposed and collected by the courts pursuant to this*
18 *section, for the purpose of maintaining pediatric trauma and*
19 *emergency services described in subdivision (e) of Section*
20 *1797.98a of the Health and Safety Code. The remainder of the*
21 *moneys deposited into the fund shall, upon appropriation by the*
22 *Legislature, be made available to the State Department of Health*
23 *Care Services for the nonfederal share of Medi-Cal program*
24 *expenditures related to emergency medical services.*

25 *(d) This section shall become inoperative on July 1, 2016, and,*
26 *as of January 1, 2017, is repealed, unless a later enacted statute,*
27 *that becomes operative on or before January 1, 2017, deletes or*
28 *extends the dates on which it becomes inoperative and is repealed.*

29 SEC. 1.3. Section 1797.98a of the Health and Safety Code is
30 amended to read:

31 1797.98a. (a) The fund provided for in this chapter shall be
32 known as the Maddy Emergency Medical Services (EMS) Fund.

33 (b) (1) Each county may establish an emergency medical
34 services fund, upon the adoption of a resolution by the board of
35 supervisors. The moneys in the fund shall be available for the
36 reimbursements required by this chapter. The fund shall be
37 administered by each county, except that a county electing to have
38 the state administer its medically indigent services program may
39 also elect to have its emergency medical services fund administered
40 by the state.

1 (2) Costs of administering the fund shall be reimbursed by the
2 fund in an amount that does not exceed the actual administrative
3 costs or 10 percent of the amount of the fund, whichever amount
4 is lower.

5 (3) All interest earned on moneys in the fund shall be deposited
6 in the fund for disbursement as specified in this section.

7 (4) Each administering agency may maintain a reserve of up to
8 15 percent of the amount in the portions of the fund reimbursable
9 to physicians and surgeons, pursuant to subparagraph (A) of, and
10 to hospitals, pursuant to subparagraph (B) of, paragraph (5). Each
11 administering agency may maintain a reserve of any amount in
12 the portion of the fund that is distributed for other emergency
13 medical services purposes as determined by each county, pursuant
14 to subparagraph (C) of paragraph (5).

15 (5) The amount in the fund, reduced by the amount for
16 administration and the reserve, shall be utilized to reimburse
17 physicians and surgeons and hospitals for patients who do not
18 make payment for emergency medical services and for other
19 emergency medical services purposes as determined by each county
20 according to the following schedule:

21 (A) Fifty-eight percent of the balance of the fund shall be
22 distributed to physicians and surgeons for emergency services
23 provided by all physicians and surgeons, except those physicians
24 and surgeons employed by county hospitals, in general acute care
25 hospitals that provide basic, comprehensive, or standby emergency
26 services pursuant to paragraph (3) or (5) of subdivision (f) of
27 Section 1797.98e up to the time the patient is stabilized.

28 (B) Twenty-five percent of the fund shall be distributed only to
29 hospitals providing disproportionate trauma and emergency medical
30 care services.

31 (C) Seventeen percent of the fund shall be distributed for other
32 emergency medical services purposes as determined by each
33 county, including, but not limited to, the funding of regional poison
34 control centers. Funding may be used for purchasing equipment
35 and for capital projects only to the extent that these expenditures
36 support the provision of emergency services and are consistent
37 with the intent of this chapter.

38 (c) The source of the moneys in the fund shall be the penalty
39 assessment made for this purpose, as provided in Section 76000
40 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.98c for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held and rolled over to the next year pursuant to paragraph (4) of subdivision (b) shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year.

(e) Of the money deposited into the fund pursuant to Section 76000.5 of the Government Code, 15 percent shall be utilized to provide funding for all pediatric trauma centers throughout the county, both publicly and privately owned and operated. The expenditure of money shall be limited to reimbursement to physicians and surgeons, and to hospitals for patients who do not make payment for emergency care services in hospitals up to the point of stabilization, or to hospitals for expanding the services provided to pediatric trauma patients at trauma centers and other hospitals providing care to pediatric trauma patients, or at pediatric trauma centers, including the purchase of equipment. Local emergency medical services (EMS) agencies may conduct a needs assessment of pediatric trauma services in the county to allocate these expenditures. Counties that do not maintain a pediatric trauma center shall utilize the money deposited into the fund pursuant to Section 76000.5 of the Government Code to improve access to, and coordination of, pediatric trauma and emergency services in the county, with preference for funding given to hospitals that specialize in services to children, and physicians and surgeons who provide emergency care for children. Funds spent for the purposes of this section, shall be known as Richie's Fund. This subdivision shall remain in effect only until ~~January 1, 2014~~ *July 1, 2016*, and shall have no force or effect on or after that date, unless a later enacted statute, that is chaptered before ~~January 1, 2014~~ *July 1, 2016*, deletes or extends that date.

(f) Costs of administering money deposited into the fund pursuant to Section 76000.5 of the Government Code shall be reimbursed from the money collected in an amount that does not exceed the actual administrative costs or 10 percent of the money collected, whichever amount is lower. This subdivision shall remain

1 in effect only until January 1, 2014, and shall have no force or
2 effect on or after that date, unless a later enacted statute, that is
3 chaptered before January 1, 2014, deletes or extends that date.

4 *SEC. 1.4. Section 12693.43 of the Insurance Code is amended*
5 *to read:*

6 12693.43. (a) Applicants applying to the purchasing pool shall
7 agree to pay family contributions, unless the applicant has a family
8 contribution sponsor. Family contribution amounts consist of the
9 following two components:

10 (1) The flat fees described in subdivision (b) or (d).

11 (2) Any amounts that are charged to the program by participating
12 health, dental, and vision plans selected by the applicant that exceed
13 the cost to the program of the highest cost Family Value Package
14 in a given geographic area.

15 (b) In each geographic area, the board shall designate one or
16 more Family Value Packages for which the required total family
17 contribution is:

18 (1) Seven dollars (\$7) per child with a maximum required
19 contribution of fourteen dollars (\$14) per month per family for
20 applicants with annual household incomes up to and including 150
21 percent of the federal poverty level.

22 (2) (A) Nine dollars (\$9) per child with a maximum required
23 contribution of twenty-seven dollars (\$27) per month per family
24 for applicants with annual household incomes greater than 150
25 percent and up to and including 200 percent of the federal poverty
26 level and for applicants on behalf of children described in clause
27 (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of
28 Section 12693.70.

29 (B) Commencing the first day of the fifth month following the
30 enactment of the 2008–09 Budget Act, the family contribution
31 pursuant to this paragraph shall be twelve dollars (\$12) per child
32 with a maximum required contribution of thirty-six dollars (\$36)
33 per month per family.

34 (C) Commencing November 1, 2009, the family contribution
35 pursuant to this paragraph shall be sixteen dollars (\$16) per child
36 with a maximum required contribution of forty-eight dollars (\$48)
37 per month per family.

38 (D) *Subject to prior federal authorization, the family*
39 *contribution pursuant to this paragraph shall be thirty dollars*
40 *(\$30) per child with a maximum required contribution of ninety*

1 *dollars (\$90) per month per family, or any lesser increase in family*
2 *contributions as is authorized by the federal Department of Health*
3 *and Human Services. The family contribution required by this*
4 *subparagraph shall commence the first day of the third month*
5 *following the later of the following:*

6 *(i) The effective date of the act adding this subparagraph.*

7 *(ii) Receipt of federal authorization for the contribution in the*
8 *form of an approved amendment to California's state plan under*
9 *Title XXI of the federal Social Security Act or a waiver of one or*
10 *more requirements of Title XXI of the federal Social Security Act.*

11 (3) (A) On and after July 1, 2005, fifteen dollars (\$15) per child
12 with a maximum required contribution of forty-five dollars (\$45)
13 per month per family for applicants with annual household income
14 to which subparagraph (B) of paragraph (6) of subdivision (a) of
15 Section 12693.70 is applicable. Notwithstanding any other
16 provision of law, if an application with an effective date prior to
17 July 1, 2005, was based on annual household income to which
18 subparagraph (B) of paragraph (6) of subdivision (a) of Section
19 12693.70 is applicable, then this subparagraph shall be applicable
20 to the applicant on July 1, 2005, unless subparagraph (B) of
21 paragraph (6) of subdivision (a) of Section 12693.70 is no longer
22 applicable to the relevant family income. The program shall provide
23 prior notice to any applicant for currently enrolled subscribers
24 whose premium will increase on July 1, 2005, pursuant to this
25 subparagraph and, prior to the date the premium increase takes
26 effect, shall provide that applicant with an opportunity to
27 demonstrate that subparagraph (B) of paragraph (6) of subdivision
28 (a) of Section 12693.70 is no longer applicable to the relevant
29 family income.

30 (B) Commencing the first day of the fifth month following the
31 enactment of the 2008–09 Budget Act, the family contribution
32 pursuant to this paragraph shall be seventeen dollars (\$17) per
33 child with a maximum required contribution of fifty-one dollars
34 (\$51) per month per family.

35 (C) Commencing November 1, 2009, the family contribution
36 pursuant to this paragraph shall be twenty-four dollars (\$24) per
37 child with a maximum required contribution of seventy-two dollars
38 (\$72) per month per family.

39 (D) *Subject to prior federal authorization, the family*
40 *contribution pursuant to this paragraph shall be forty-two dollars*

1 (\$42) per child with a maximum required contribution of one
2 hundred twenty-six dollars (\$126) per month per family, or any
3 lesser increase in family contributions as is authorized by the
4 federal Department of Health and Human Services. The family
5 contribution required by this subparagraph shall commence the
6 first day of the third month following the later of the following:

7 (i) The effective date of the act adding this subparagraph.

8 (ii) Receipt of federal authorization for the contribution in the
9 form of an approved amendment to California's state plan under
10 Title XXI of the federal Social Security Act or a waiver of one or
11 more requirements of Title XXI of the federal Social Security Act.

12 (c) Combinations of health, dental, and vision plans that are
13 more expensive to the program than the highest cost Family Value
14 Package may be offered to and selected by applicants. However,
15 the cost to the program of those combinations that exceeds the
16 price to the program of the highest cost Family Value Package
17 shall be paid by the applicant as part of the family contribution.

18 (d) The board shall provide a family contribution discount to
19 those applicants who select the health plan in a geographic area
20 that has been designated as the Community Provider Plan. The
21 discount shall reduce the portion of the family contribution
22 described in subdivision (b) to the following:

23 (1) A family contribution of four dollars (\$4) per child with a
24 maximum required contribution of eight dollars (\$8) per month
25 per family for applicants with annual household incomes up to and
26 including 150 percent of the federal poverty level.

27 (2) (A) Six dollars (\$6) per child with a maximum required
28 contribution of eighteen dollars (\$18) per month per family for
29 applicants with annual household incomes greater than 150 percent
30 and up to and including 200 percent of the federal poverty level
31 and for applicants on behalf of children described in clause (ii) of
32 subparagraph (A) of paragraph (6) of subdivision (a) of Section
33 12693.70.

34 (B) Commencing the first day of the fifth month following the
35 enactment of the 2008–09 Budget Act, the family contribution
36 pursuant to this paragraph shall be nine dollars (\$9) per child with
37 a maximum required contribution of twenty-seven dollars (\$27)
38 per month per family.

39 (C) Commencing November 1, 2009, the family contribution
40 pursuant to this paragraph shall be thirteen dollars (\$13) per child

1 with a maximum required contribution of thirty-nine dollars (\$39)
2 per month per family.

3 *(D) Subject to prior federal authorization, the family*
4 *contribution pursuant to this paragraph shall be twenty-seven*
5 *dollars (\$27) per child with a maximum required contribution of*
6 *eighty-one dollars (\$81) per month per family, or any lesser*
7 *increase in family contributions as is authorized by the federal*
8 *Department of Health and Human Services. The family contribution*
9 *required by this subparagraph shall commence the first day of the*
10 *third month following the later of the following:*

11 *(i) The effective date of the act adding this subparagraph.*

12 *(ii) Receipt of federal authorization for the contribution in the*
13 *form of an approved amendment to California's state plan under*
14 *Title XXI of the federal Social Security Act or a waiver of one or*
15 *more requirements of Title XXI of the federal Social Security Act.*

16 (3) (A) On and after July 1, 2005, twelve dollars (\$12) per child
17 with a maximum required contribution of thirty-six dollars (\$36)
18 per month per family for applicants with annual household income
19 to which subparagraph (B) of paragraph (6) of subdivision (a) of
20 Section 12693.70 is applicable. Notwithstanding any other
21 provision of law, if an application with an effective date prior to
22 July 1, 2005, was based on annual household income to which
23 subparagraph (B) of paragraph (6) of subdivision (a) of Section
24 12693.70 is applicable, then this subparagraph shall be applicable
25 to the applicant on July 1, 2005, unless subparagraph (B) of
26 paragraph (6) of subdivision (a) of Section 12693.70 is no longer
27 applicable to the relevant family income. The program shall provide
28 prior notice to any applicant for currently enrolled subscribers
29 whose premium will increase on July 1, 2005, pursuant to this
30 subparagraph and, prior to the date the premium increase takes
31 effect, shall provide that applicant with an opportunity to
32 demonstrate that subparagraph (B) of paragraph (6) of subdivision
33 (a) of Section 12693.70 is no longer applicable to the relevant
34 family income.

35 (B) Commencing the first day of the fifth month following the
36 enactment of the 2008–09 Budget Act, the family contribution
37 pursuant to this paragraph shall be fourteen dollars (\$14) per child
38 with a maximum required contribution of forty-two dollars (\$42)
39 per month per family.

1 (C) Commencing November 1, 2009, the family contribution
2 pursuant to this paragraph shall be twenty-one dollars (\$21) per
3 child with a maximum required contribution of sixty-three dollars
4 (\$63) per month per family.

5 (D) *Subject to prior federal authorization, the family*
6 *contribution pursuant to this paragraph shall be thirty-nine dollars*
7 *(\$39) per child with a maximum required contribution of one*
8 *hundred seventeen dollars (\$117) per month per family, or any*
9 *lesser increase in family contributions as is authorized by the*
10 *federal Department of Health and Human Services. The family*
11 *contribution required by this subparagraph shall commence the*
12 *first day of the third month following the later of the following:*

13 (i) *The effective date of the act adding this subparagraph.*

14 (ii) *Receipt of federal authorization for the contribution in the*
15 *form of an approved amendment to California's state plan under*
16 *Title XXI of the federal Social Security Act or a waiver of one or*
17 *more requirements of Title XXI of the federal Social Security Act.*

18 (e) Applicants, but not family contribution sponsors, who pay
19 three months of required family contributions in advance shall
20 receive the fourth consecutive month of coverage with no family
21 contribution required.

22 (f) Applicants, but not family contribution sponsors, who pay
23 the required family contributions by an approved means of
24 electronic fund transfer shall receive a 25-percent discount from
25 the required family contributions.

26 (g) It is the intent of the Legislature that the family contribution
27 amounts described in this section comply with the premium cost
28 sharing limits contained in Section 2103 of Title XXI of the Social
29 Security Act. If the amounts described in subdivision (a) are not
30 approved by the federal government, the board may adjust these
31 amounts to the extent required to achieve approval of the state
32 plan.

33 (h) The adoption and one readoption of regulations to implement
34 paragraph (3) of subdivision (b) and paragraph (3) of subdivision
35 (d) shall be deemed to be an emergency and necessary for the
36 immediate preservation of public peace, health, and safety, or
37 general welfare for purposes of Sections 11346.1 and 11349.6 of
38 the Government Code, and the board is hereby exempted from the
39 requirement that it describe specific facts showing the need for
40 immediate action and from review by the Office of Administrative

1 Law. For purpose of subdivision (e) of Section 11346.1 of the
2 Government code, the 120-day period, as applicable to the effective
3 period of an emergency regulatory action and submission of
4 specified materials to the Office of Administrative law, is hereby
5 extended to 180 days.

6 (i) The board may adopt, and may only one-time readopt,
7 regulations to implement the changes to this section that are
8 effective the first day of the fifth month following the enactment
9 of the 2008–09 Budget Act. The adoption and one-time readoption
10 of a regulation authorized by this section is deemed to address an
11 emergency, for purposes of Sections 11346.1 and 11349.6 of the
12 Government Code, and the board is hereby exempted for this
13 purpose from the requirements of subdivision (b) of Section
14 11346.1 of the Government Code.

15 (j) The program shall provide prior notice to any applicant for
16 a subscriber whose premium will increase as a result of
17 amendments made to this section ~~by the act that added this~~
18 ~~subdivision~~ and shall provide the applicant with an opportunity to
19 demonstrate that, based on reduced family income, the subscriber
20 is subject to a lower premium pursuant to this section.

21 (k) *The adoption and readoption, by the board, of regulations*
22 *to implement the changes made to this section by the act that added*
23 *this subdivision shall be deemed to be an emergency and necessary*
24 *to avoid serious harm to the public peace, health, safety, or general*
25 *welfare for purposes of Sections 11346.1 and 11349.6 of the*
26 *Government Code, and the board is hereby exempted from the*
27 *requirement that it describe facts showing the need for immediate*
28 *action and from review by the Office of Administrative Law.*

29 SEC. 1.5. *Section 12693.60 of the Insurance Code is amended*
30 *to read:*

31 12693.60. (a) Coverage provided to subscribers shall meet the
32 federal coverage requirements in Section 2103 of Title XXI of the
33 Social Security Act. ~~The~~ *Except as otherwise provided in this part,*
34 *the* covered health benefits provided to subscribers shall be
35 equivalent to those provided to state employees through the Public
36 Employees' Retirement System ~~on January 1, 1998 for the most~~
37 *recent plan year preceding the applicable program plan year,*
38 except that the plans may provide a mechanism for inpatient
39 hospital care provided under the mental health benefit through
40 which applicants may agree to a treatment plan in which each

1 inpatient day may be substituted for two residential treatment days
2 or three day treatment program days.

3 (b) *The adoption and readoption, by the Managed Risk Medical*
4 *Insurance Board, of regulations to implement the changes made*
5 *to this section by the act that added this subdivision, shall be*
6 *deemed to be an emergency and necessary to avoid serious harm*
7 *to the public peace, health, safety, or general welfare for purposes*
8 *of Sections 11346.1 and 11349.6 of the Government Code, and*
9 *the board is hereby exempted from the requirement that it describe*
10 *facts showing the need for immediate action and from review by*
11 *the Office of Administrative Law.*

12 SEC. 1.7. Section 12693.615 of the Insurance Code is amended
13 to read:

14 12693.615. (a) The board shall establish the required subscriber
15 copayment levels for specific benefits consistent with the
16 limitations of Section 2103 of Title XXI of the Social Security
17 Act. The copayment levels established by the board shall, to the
18 extent possible, reflect the copayment levels established for state
19 employees, effective January 1, 1998, through the Public
20 Employees' Retirement System.—~~Under~~ *Except as otherwise*
21 *provided in this section, under no circumstances shall copayments*
22 *exceed the copayment level established for state employees;*
23 ~~effective, January 1, 1998, for the most recent plan year preceding~~
24 *the applicable program plan year through the Public Employees'*
25 *Retirement System. Total annual copayments charged to*
26 *subscribers shall not exceed two hundred fifty dollars (\$250) per*
27 *family. The board shall instruct participating health plans to work*
28 *with their provider networks to provide for extended payment*
29 *plans for subscribers utilizing a significant number of health*
30 *services for which copayments are charged. The board shall track*
31 *the number of subscribers who meet the copayment maximum in*
32 *each year and make adjustments in the amount if a significant*
33 *number of subscribers reach the copayment maximum.*

34 (b) No deductibles shall be charged to subscribers for health
35 benefits.

36 (c) Coverage provided to subscribers shall not contain any
37 preexisting condition exclusion requirements.

38 (d) No participating health, dental, or vision plan shall exclude
39 any subscriber on the basis of any actual or expected health

1 condition or claims experience of that subscriber or a member of
2 that subscriber's family.

3 (e) There shall be no variations in rates charged to subscribers
4 including premiums and copayments, on the basis of any actual
5 or expected health condition or claims experience of any subscriber
6 or subscriber's family member. The only variation in rates charged
7 to subscribers, including copayments and premiums, that shall be
8 permitted is that which is expressly authorized by Section
9 12693.43.

10 (f) There shall be no copayments for preventive services as
11 defined in Section 1367.35 of the Health and Safety Code.

12 (g) There shall be no annual or lifetime benefit maximums in
13 any of the coverage provided under the program.

14 (h) Plans that receive purchasing credits pursuant to Section
15 12693.39 shall comply with subdivisions (b), (c), (d), (e), (f), and
16 (g).

17 (i) *(1) Effective October 1, 2011, or the first day of the month*
18 *following 120 days after the federal approval required by*
19 *subparagraphs (A) and (B) of paragraph (3), whichever occurs*
20 *later, copayments for emergency room and inpatient hospital*
21 *services shall be set by the board as follows:*

22 (A) *Fifty dollars (\$50) for outpatient emergency room services.*
23 *The copayment shall be waived if the subscriber is hospitalized.*

24 (B) *One hundred dollars (\$100) for each hospital inpatient day*
25 *up to a maximum of two hundred dollars (\$200) per admission.*

26 (2) *The changes made to the copayments in paragraph (1) shall*
27 *not increase the maximum annual copayment of two hundred fifty*
28 *dollars (\$250) per family described in subdivision (a).*

29 (3) *The changes made to the copayments in paragraph (1) shall*
30 *be implemented only if, and to the extent that, both of the following*
31 *occur:*

32 (A) *The state receives prior federal authorization to implement*
33 *the copayments in the form of an approved amendment to the state*
34 *plan under Title XXI of the federal Social Security Act or a waiver*
35 *of one or more requirements of Title XXI of the federal Social*
36 *Security Act.*

37 (B) *The state receives prior federal authorization for, and*
38 *implements, copayments in the same amounts for all children*
39 *enrolled in the Medi-Cal program through an approved amendment*
40 *to the state plan under Title XIX of the federal Social Security Act*

1 *or a waiver of one or more requirements of Title XIX of the federal*
2 *Social Security Act.*

3 *(4) Notwithstanding paragraph (1), the state shall not implement*
4 *the copayments otherwise required by this subdivision at an earlier*
5 *date than the state implements copayments in the same amounts*
6 *for all children in the Medi-Cal program.*

7 *(5) The adoption and readoption, by the Managed Risk Medical*
8 *Insurance Board, of regulations to implement the changes made*
9 *to this section by the act that added this subdivision, shall be*
10 *deemed to be an emergency and necessary to avoid serious harm*
11 *to the public peace, health, safety, or general welfare for purposes*
12 *of Sections 11346.1 and 11349.6 of the Government Code, and*
13 *the board is hereby exempted from the requirement that it describe*
14 *facts showing the need for immediate action and from review by*
15 *the Office of Administrative Law.*

16 *SEC. 2. Section 12693.65 of the Insurance Code is amended*
17 *to read:*

18 *12693.65. (a) Vision benefits shall be provided to subscribers*
19 *and shall meet the federal coverage requirements in Section 2103*
20 *of Title XXI of the Social Security Act.*

21 *(b) The covered benefits shall be equivalent to those provided*
22 *to state employees through the Department of Personnel*
23 *Administration on July 1, 1997, except for tinted lenses and also*
24 *photochromatic lenses, unless otherwise deemed medically*
25 *necessary.*

26 *(c) The board shall establish the required subscriber copayment*
27 *levels for vision benefits consistent with the limitations of Section*
28 *2103 of Title XXI of the Social Security Act. The copayment levels*
29 *established by the board shall, to the extent possible, reflect the*
30 *copayment levels provided to state employees through the*
31 *Department of Personnel Administration on July 1, 1997.*

32 ~~*(d) The board may adopt, and may only one-time readopt,*~~
33 ~~*regulations to implement subdivision (b). The adoption and*~~
34 ~~*one-time readoption of a regulation authorized by this subdivision*~~
35 ~~*is deemed to address an emergency, for purposes of Sections*~~
36 ~~*11346.1 and 11349.6 of the Government Code, and the board is*~~
37 ~~*hereby exempted for this purpose from the requirements of*~~
38 ~~*subdivision (b) of Section 11346.1 of the Government Code.*~~

39 *(d) From March 1, 2011, to June 30, 2012, inclusive, the*
40 *adoption and readoption, by the board, of regulations to modify*

1 vision benefits pursuant to this section, including, but not limited
2 to, restriction of providers through which covered vision benefits
3 may be obtained, restriction of benefits for services from
4 nonparticipating providers, or restriction of products and materials
5 provided as benefits pursuant to this section, shall be deemed to
6 be an emergency and necessary to avoid serious harm to the public
7 peace, health, safety, or general welfare for purposes of Sections
8 11346.1 and 11349.6 of the Government Code, and the board is
9 hereby exempted from the requirement that it describe facts
10 showing the need for immediate action and from review by the
11 Office of Administrative Law.

12 SEC. 3. Section 12009 of the Revenue and Taxation Code is
13 amended to read:

14 12009. (a) “Medi-Cal managed care plan” or “plan” means
15 any individual, organization, or entity, other than an insurer as
16 described in Section 12003 or a dental managed care plan as
17 described in Section 14087.46 of the Welfare and Institutions
18 Code, that enters into a contract with the State Department of
19 Health Care Services pursuant to Article 2.7 (commencing with
20 Section 14087.3), Article 2.8 (commencing with Section 14087.5),
21 Article 2.81 (commencing with Section 14087.96), Article 2.9
22 (commencing with Section 14088), or Article 2.91 (commencing
23 with Section 14089) of Chapter 7 of, or pursuant to Article 1
24 (commencing with Section 14200) or Article 7 (commencing with
25 Section 14490) of Chapter 8 of, Part 3 of Division 9 of the Welfare
26 and Institutions Code.

27 (b) This section shall become inoperative on ~~July 1, 2011~~
28 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ July 1, 2014, is
29 repealed, unless a later enacted statute, that becomes operative on
30 or before ~~January 1, 2012~~ July 1, 2014, deletes or extends the dates
31 on which it becomes inoperative and is repealed.

32 SEC. 4. Section 12201 of the Revenue and Taxation Code, as
33 added by Section 31 of Chapter 717 of the Statutes of 2010, is
34 amended to read:

35 12201. (a) Every insurer and Medi-Cal managed care plan
36 doing business in this state shall annually pay to the state a tax on
37 the bases, at the rates, and subject to the deductions from the tax
38 hereinafter specified. For purposes of the tax imposed by this
39 chapter, “insurer” shall be deemed to include a home protection
40 company as defined in Section 12740 of the Insurance Code.

1 (b) Notwithstanding Section 13340 of the Government Code,
2 the revenues derived from the imposition of the tax by this chapter
3 on Medi-Cal managed care plans are hereby continuously
4 appropriated as follows:

5 (1) A percentage of the revenues derived from the imposition
6 of the tax by this chapter on Medi-Cal managed care plans equal
7 to the difference between 100 percent and the applicable federal
8 medical assistance percentage (FMAP) to the department for
9 purposes of the Medi-Cal program.

10 (2) After deducting the revenues appropriated pursuant to
11 paragraph (1), any remaining revenue to the Managed Risk Medical
12 Insurance Board for purposes of the Healthy Families Program.

13 (c) The Insurance Commissioner shall report the amount of
14 revenue derived from the tax imposed on Medi-Cal managed care
15 plans pursuant to this section to the California Health and Human
16 Services Agency, the Joint Legislative Budget Committee, and the
17 Department of Finance.

18 ~~(d) This section shall become operative on July 1, 2010.~~

19 *(d) Notwithstanding any other law, the Controller may use the*
20 *funds in the Children's Health and Human Services Special Fund*
21 *for cash-flow loans to the General Fund as provided in Sections*
22 *16310 and 16381 of the Government Code.*

23 (e) This section shall become inoperative on ~~July 1, 2011~~
24 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
25 repealed, unless a later enacted statute, that becomes operative on
26 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
27 on which it becomes inoperative and is repealed.

28 *SEC. 5. Section 12201 of the Revenue and Taxation Code, as*
29 *amended by Section 32 of Chapter 717 of the Statutes of 2010, is*
30 *amended to read:*

31 12201. (a) Every insurer doing business in this state shall
32 annually pay to the state a tax on the bases, at the rates, and subject
33 to the deductions from the tax hereinafter specified. For purposes
34 of the tax imposed by this chapter, "insurer" shall be deemed to
35 include a home protection company as defined in Section 12740
36 of the Insurance Code.

37 (b) This section shall become operative on ~~July 1, 2011~~ *January*
38 *1, 2014.*

1 *SEC. 6. Section 12204 of the Revenue and Taxation Code, as*
2 *amended by Section 33 of Chapter 717 of the Statutes of 2010, is*
3 *amended to read:*

4 12204. (a) The tax imposed on insurers by this chapter is in
5 lieu of all other taxes and licenses, state, county, and municipal,
6 upon those insurers and their property, except:

7 (1) Taxes upon their real estate.

8 (2) Any retaliatory exactions imposed by paragraph (3) of
9 subdivision (f) of Section 28 of Article XIII of the Constitution.

10 (3) The tax on ocean marine insurance.

11 (4) Motor vehicle and other vehicle registration license fees and
12 any other tax or license fee imposed by the state upon vehicles,
13 motor vehicles or the operation thereof.

14 (5) That each corporate or other attorney-in-fact of a reciprocal
15 or interinsurance exchange shall be subject to all taxes imposed
16 upon corporations or others doing business in the state, other than
17 taxes on income derived from its principal business as
18 attorney-in-fact.

19 (b) This section shall not apply to any Medi-Cal managed care
20 plan and to any tax imposed on that plan by this chapter.

21 (c) This section shall become inoperative on ~~July 1, 2011~~
22 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
23 repealed, unless a later enacted statute, that becomes operative on
24 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
25 on which it becomes inoperative and is repealed.

26 *SEC. 7. Section 12204 of the Revenue and Taxation Code, as*
27 *amended by Section 34 of Chapter 717 of the Statutes of 2010, is*
28 *amended to read:*

29 12204. (a) The tax imposed on insurers by this chapter is in
30 lieu of all other taxes and licenses, state, county, and municipal,
31 upon those insurers and their property, except:

32 (1) Taxes upon their real estate.

33 (2) Any retaliatory exactions imposed by paragraph (3) of
34 subdivision (f) of Section 28 of Article XIII of the California
35 Constitution.

36 (3) The tax on ocean marine insurance.

37 (4) Motor vehicle and other vehicle registration license fees and
38 any other tax or license fee imposed by the state upon vehicles,
39 motor vehicles or the operation thereof.

1 (5) That each corporate or other attorney-in-fact of a reciprocal
2 or interinsurance exchange shall be subject to all taxes imposed
3 upon corporations or others doing business in the state, other than
4 taxes on income derived from its principal business as
5 attorney-in-fact.

6 (b) This section shall become operative on ~~July 1, 2011~~ *January*
7 *1, 2014*.

8 *SEC. 8. Section 12207 of the Revenue and Taxation Code is*
9 *amended to read:*

10 12207. (a) Notwithstanding any other provision of this part,
11 no credit shall be allowed under Section 12206, 12208, or 12209
12 against the tax imposed on Medi-Cal managed care plans pursuant
13 to Section 12201.

14 (b) This section shall become inoperative on ~~July 1, 2011~~
15 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
16 repealed, unless a later enacted statute, that becomes operative on
17 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
18 on which it becomes inoperative and is repealed.

19 *SEC. 9. Section 12242 of the Revenue and Taxation Code is*
20 *amended to read:*

21 12242. This article shall become inoperative on ~~July 1, 2011~~
22 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
23 repealed, unless a later enacted statute, that becomes operative on
24 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
25 on which it becomes inoperative and is repealed.

26 *SEC. 10. Section 12251 of the Revenue and Taxation Code, as*
27 *amended by Section 37 of Chapter 717 of the Statutes of 2010, is*
28 *amended to read:*

29 12251. (a) For the calendar year 1970, and each calendar year
30 thereafter, insurers transacting insurance in this state and whose
31 annual tax for the preceding calendar year was five thousand dollars
32 (\$5,000) or more shall make prepayments of the annual tax for the
33 current calendar year imposed by Section 28 of Article XIII of the
34 California Constitution and this part, provided that no prepayments
35 shall be made with respect to the tax on ocean marine insurance
36 underwriting profit or any retaliatory tax.

37 (b) Medi-Cal managed care plans shall make prepayments of
38 the tax imposed by Section 12201 for the current calendar year,
39 except that no prepayments shall be required prior to the effective
40 date of the act adding this subdivision, and no penalties and interest

1 shall be imposed pursuant to Section 12261 for not making those
2 prepayments.

3 (c) This section shall become inoperative on ~~July 1, 2011~~
4 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
5 repealed, unless a later enacted statute, that becomes operative on
6 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
7 on which it becomes inoperative and is repealed.

8 *SEC. 11. Section 12251 of the Revenue and Taxation Code, as*
9 *amended by Section 38 of Chapter 717 of the Statutes of 2010, is*
10 *amended to read:*

11 12251. (a) For the calendar year 1970, and each calendar year
12 thereafter, insurers transacting insurance in this state and whose
13 annual tax for the preceding calendar year was five thousand dollars
14 (\$5,000) or more shall make prepayments of the annual tax for the
15 current calendar year imposed by Section 28 of Article XIII of the
16 California Constitution and this part, provided that no prepayments
17 shall be made with respect to the tax on ocean marine insurance
18 underwriting profit or any retaliatory tax.

19 (b) This section shall become operative on ~~July 1, 2011~~ *January*
20 *1, 2014*.

21 *SEC. 12. Section 12253 of the Revenue and Taxation Code, as*
22 *amended by Section 39 of Chapter 717 of the Statutes of 2010, is*
23 *amended to read:*

24 12253. (a) Each insurer and Medi-Cal managed care plan
25 required to make prepayments shall remit them on or before each
26 of the dates of April 1st, June 1st, September 1st, and December
27 1st of the current calendar year. Remittances for prepayments shall
28 be made payable to the Controller and shall be delivered to the
29 office of the commissioner, accompanied by a prepayment form
30 prescribed by the commissioner.

31 (b) This section shall become inoperative on ~~July 1, 2011~~
32 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
33 repealed, unless a later enacted statute, that becomes operative on
34 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
35 on which it becomes inoperative and is repealed.

36 *SEC. 13. Section 12253 of the Revenue and Taxation Code, as*
37 *amended by Section 40 of Chapter 717 of the Statutes of 2010, is*
38 *amended to read:*

39 12253. (a) Each insurer required to make prepayments shall
40 remit them on or before each of the dates of April 1st, June 1st,

1 September 1st, and December 1st of the current calendar year.
2 Remittances for prepayments shall be made payable to the
3 Controller and shall be delivered to the office of the commissioner,
4 accompanied by a prepayment form prescribed by the
5 commissioner.

6 (b) This section shall become operative on ~~July 1, 2011~~ *January*
7 *1, 2014.*

8 *SEC. 14. Section 12254 of the Revenue and Taxation Code, as*
9 *amended by Section 41 of Chapter 717 of the Statutes of 2010, is*
10 *amended to read:*

11 12254. (a) (1) For each insurer, the amount of each
12 prepayment shall be 25 percent of the amount of the annual
13 insurance tax liability reported on the return of the insurer for the
14 preceding calendar year.

15 (2) For each Medi-Cal managed care plan, the amount of each
16 prepayment shall be 25 percent of the amount of tax the plan
17 estimates as the amount of tax imposed by Section 12201 with
18 respect to the plan.

19 (b) In establishing the prepayment amount of an insurer that
20 has acquired the business of another insurer, the amount of tax
21 liability of the acquiring insurer reported for the preceding calendar
22 year shall be deemed to include the amount of tax liability of the
23 acquired insurer reported for that year.

24 (c) This section shall become inoperative on ~~July 1, 2011~~
25 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
26 repealed, unless a later enacted statute, that becomes operative on
27 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
28 on which it becomes inoperative and is repealed.

29 *SEC. 15. Section 12254 of the Revenue and Taxation Code, as*
30 *amended by Section 42 of Chapter 717 of the Statutes of 2010, is*
31 *amended to read:*

32 12254. (a) The amount of each prepayment shall be 25 percent
33 of the amount of the annual insurance tax liability reported on the
34 return of the insurer for the preceding calendar year.

35 (b) In establishing the prepayment amount of an insurer that
36 has acquired the business of another insurer, the amount of tax
37 liability of the acquiring insurer reported for the preceding calendar
38 year shall be deemed to include the amount of tax liability of the
39 acquired insurer reported for that year.

(c) This section shall become operative on ~~July 1, 2011~~ January 1, 2014.

SEC. 16. Section 12257 of the Revenue and Taxation Code, as amended by Section 43 of Chapter 717 of the Statutes of 2010, is amended to read:

12257. (a) If the total amount of prepayments for any calendar year exceeds the amount of annual tax for that year, the excess shall be treated as an overpayment of annual tax and, at the election of the insurer or Medi-Cal managed care plan, may be credited against the amounts due and payable for the first prepayment of the following year. Any amount of the overpayment not so credited shall be allowed as a credit or refund under Article 2 (commencing with Section 12977) of Chapter 7 of this part.

(b) This section shall become inoperative on ~~July 1, 2011~~ January 1, 2014, and, as of ~~January 1, 2012~~ July 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before ~~January 1, 2012~~ July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 17. Section 12257 of the Revenue and Taxation Code, as amended by Section 44 of Chapter 717 of the Statutes of 2010, is amended to read:

12257. (a) If the total amount of prepayments for any calendar year exceeds the amount of annual tax for that year, the excess shall be treated as an overpayment of annual tax and, at the election of the insurer, may be credited against the amounts due and payable for the first prepayment of the following year. Any amount of the overpayment not so credited shall be allowed as a credit or refund under Article 2 (commencing with Section 12977) of Chapter 7 of this part.

(b) This section shall become operative on ~~July 1, 2011~~ January 1, 2014.

SEC. 18. Section 12258 of the Revenue and Taxation Code, as amended by Section 45 of Chapter 717 of the Statutes of 2010, is amended to read:

12258. (a) Any insurer or Medi-Cal managed care plan that fails to pay any prepayment within the time required shall pay a penalty of 10 percent of the amount of the required prepayment, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the prepayment until the date of payment but not for any period

1 after the due date of the annual tax. Assessments of prepayment
2 deficiencies may be made in the manner provided by deficiency
3 assessments of the annual tax.

4 (b) This section shall become inoperative on ~~July 1, 2011~~
5 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
6 repealed, unless a later enacted statute, that becomes operative on
7 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
8 on which it becomes inoperative and is repealed.

9 *SEC. 19. Section 12258 of the Revenue and Taxation Code, as*
10 *amended by Section 46 of Chapter 717 of the Statutes of 2010, is*
11 *amended to read:*

12 12258. (a) Any insurer that fails to pay any prepayment within
13 the time required shall pay a penalty of 10 percent of the amount
14 of the required prepayment, plus interest at the modified adjusted
15 rate per month, or fraction thereof, established pursuant to Section
16 6591.5, from the due date of the prepayment until the date of
17 payment but not for any period after the due date of the annual
18 tax. Assessments of prepayment deficiencies may be made in the
19 manner provided by deficiency assessments of the annual tax.

20 (b) This section shall become operative on ~~July 1, 2011~~ *January*
21 *1, 2014*.

22 *SEC. 20. Section 12260 of the Revenue and Taxation Code, as*
23 *amended by Section 47 of Chapter 717 of the Statutes of 2010, is*
24 *amended to read:*

25 12260. (a) Notwithstanding any other provision of this article,
26 the commissioner may relieve an insurer or Medi-Cal managed
27 care plan of its obligation to make prepayments where the insurer
28 or Medi-Cal managed care plan establishes to the satisfaction of
29 the commissioner that the insurer has ceased to transact insurance
30 in this state or the Medi-Cal managed care plan has ceased to
31 operate a plan in this state, or the insurer's or Medi-Cal managed
32 care plan's annual tax for the current year will be less than five
33 thousand dollars (\$5,000).

34 (b) This section shall become inoperative on ~~July 1, 2011~~
35 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
36 repealed, unless a later enacted statute, that becomes operative on
37 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
38 on which it becomes inoperative and is repealed.

1 *SEC. 21. Section 12260 of the Revenue and Taxation Code, as*
2 *amended by Section 48 of Chapter 717 of the Statutes of 2010, is*
3 *amended to read:*

4 12260. (a) Notwithstanding any other provision of this article,
5 the commissioner may relieve an insurer of its obligation to make
6 prepayments where the insurer establishes to the satisfaction of
7 the commissioner that either the insurer has ceased to transact
8 insurance in this state, or the insurer's annual tax for the current
9 year will be less than five thousand dollars (\$5,000).

10 (b) This section shall become operative on ~~July 1, 2011~~ *January*
11 *1, 2014.*

12 *SEC. 22. Section 12301 of the Revenue and Taxation Code, as*
13 *amended by Section 49 of Chapter 717 of the Statutes of 2010, is*
14 *amended to read:*

15 12301. (a) The taxes imposed upon insurers by Section 28 of
16 Article XIII of the California Constitution and this part, except
17 with respect to taxes on ocean marine insurance and retaliatory
18 taxes, are due and payable annually on or before April 1st of the
19 year following the calendar year in which the insurer engaged in
20 the business of insurance or transacted insurance in this state. The
21 taxes imposed with respect to ocean marine insurance are due and
22 payable on or before June 15th of that year.

23 (b) With respect to Medi-Cal managed care plans, the taxes
24 imposed by Section 12201 shall be due and payable on or before
25 April 1st of the year following the calendar year in which the plan
26 contracted with the State Department of Health Care Services as
27 described in Section 12009.

28 (c) This section shall become inoperative on ~~July 1, 2011~~
29 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
30 repealed, unless a later enacted statute, that becomes operative on
31 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
32 on which it becomes inoperative and is repealed. However, any
33 tax imposed by Section 12201 shall continue to be due and payable
34 until the tax is paid.

35 *SEC. 23. Section 12301 of the Revenue and Taxation Code, as*
36 *amended by Section 50 of Chapter 717 of the Statutes of 2010, is*
37 *amended to read:*

38 12301. (a) The taxes imposed upon insurers by Section 28 of
39 Article XIII of the California Constitution and this part, except
40 with respect to taxes on ocean marine insurance and retaliatory

taxes, are due and payable annually on or before April 1st of the year following the calendar year in which the insurer engaged in the business of insurance or transacted insurance in this state. The taxes imposed with respect to ocean marine insurance are due and payable on or before June 15th of that year.

(b) This section shall become operative on ~~July 1, 2011~~ *January 1, 2014*.

SEC. 24. Section 12302 of the Revenue and Taxation Code, as amended by Section 51 of Chapter 717 of the Statutes of 2010, is amended to read:

12302. (a) On or before April 1st (or June 15th with respect to taxes on ocean marine insurance) every person that is subject to any tax imposed by Section 28 of Article XIII of the California Constitution or this part, in respect to the preceding calendar year shall file, in duplicate, a tax return with the commissioner in the form as the commissioner may prescribe. The return shall show that information pertaining to its insurance business, or in the case of a Medi-Cal managed care plan, pertaining to contracts for providing services as described in Section 12009, in this state as will reflect the basis of its tax as set forth in Chapter 2 (commencing with Section 12071) and Chapter 3 (commencing with Section 12201) of this part, the computation of the amount of tax for the period covered by the return, the total amount of any tax prepayments made pursuant to Article 5 (commencing with Section 12251) of Chapter 3 of this part, and any other information as the commissioner may require to carry out the purposes of this part. Separate returns shall be filed with respect to the following kinds of insurance:

- (1) Life insurance (or life insurance and disability insurance).
- (2) Ocean marine insurance.
- (3) Title insurance.
- (4) Insurance other than life insurance (or life insurance and disability insurance), ocean marine insurance or title insurance.

(b) This section shall become inoperative on ~~July 1, 2011~~ *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is repealed, unless a later enacted statute, that becomes operative on or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates on which it becomes inoperative and is repealed.

1 *SEC. 25. Section 12302 of the Revenue and Taxation Code, as*
2 *amended by Section 52 of Chapter 717 of the Statutes of 2010, is*
3 *amended to read:*

4 12302. (a) On or before April 1st (or June 15th with respect
5 to taxes on ocean marine insurance) every person that is subject
6 to any tax imposed by Section 28 of Article XIII of the California
7 Constitution or this part, in respect to the preceding calendar year
8 shall file, in duplicate, an insurance tax return with the
9 commissioner in the form as the commissioner may prescribe. The
10 return shall show that information pertaining to its insurance
11 business in this state as will reflect the basis of its tax as set forth
12 in Chapter 2 (commencing with Section 12071) and Chapter 3
13 (commencing with Section 12201) of this part, the computation
14 of the amount of tax for the period covered by the return, the total
15 amount of any tax prepayments made pursuant to Article 5
16 (commencing with Section 12251) of Chapter 3 of this part, and
17 any other information as the commissioner may require to carry
18 out the purposes of this part. Separate returns shall be filed with
19 respect to the following kinds of insurance:

- 20 (1) Life insurance (or life insurance and disability insurance).
21 (2) Ocean marine insurance.
22 (3) Title insurance.
23 (4) Insurance other than life insurance (or life insurance and
24 disability insurance), ocean marine insurance or title insurance.

25 (b) This section shall become operative on ~~July 1, 2011~~ *January*
26 *1, 2014.*

27 *SEC. 26. Section 12303 of the Revenue and Taxation Code, as*
28 *amended by Section 53 of Chapter 717 of the Statutes of 2010, is*
29 *amended to read:*

30 12303. (a) Every return required by this article to be filed with
31 the commissioner shall be signed by the insurer or Medi-Cal
32 managed care plan or an executive officer of the insurer or plan
33 and shall be made under oath or contain a written declaration that
34 it is made under penalty of perjury. A return of a foreign insurer
35 may be signed and verified by its manager residing within this
36 state. A return of an alien insurer may be signed and verified by
37 the United States manager of the insurer.

38 (b) This section shall become inoperative on ~~July 1, 2011~~
39 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
40 repealed, unless a later enacted statute, that becomes operative on

1 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
2 on which it becomes inoperative and is repealed.

3 *SEC. 27. Section 12303 of the Revenue and Taxation Code, as*
4 *amended by Section 54 of Chapter 717 of the Statutes of 2010, is*
5 *amended to read:*

6 12303. (a) Every return required by this article to be filed with
7 the commissioner shall be signed by the insurer or an executive
8 officer of the insurer and shall be made under oath or contain a
9 written declaration that it is made under penalty of perjury. A
10 return of a foreign insurer may be signed and verified by its
11 manager residing within this state. A return of an alien insurer may
12 be signed and verified by the United States manager of the insurer.

13 (b) This section shall become operative on ~~July 1, 2011~~ *January*
14 *1, 2014*.

15 *SEC. 28. Section 12304 of the Revenue and Taxation Code, as*
16 *amended by Section 55 of Chapter 717 of the Statutes of 2010, is*
17 *amended to read:*

18 12304. (a) Blank forms of returns shall be furnished by the
19 commissioner on application, but failure to secure the form shall
20 not relieve any insurer or Medi-Cal managed care plan from
21 making or filing a timely return.

22 (b) This section shall become inoperative on ~~July 1, 2011~~
23 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
24 repealed, unless a later enacted statute, that becomes operative on
25 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
26 on which it becomes inoperative and is repealed.

27 *SEC. 29. Section 12304 of the Revenue and Taxation Code, as*
28 *amended by Section 56 of Chapter 717 of the Statutes of 2010, is*
29 *amended to read:*

30 12304. (a) Blank forms of returns shall be furnished by the
31 commissioner on application, but failure to secure the form shall
32 not relieve any insurer from making or filing a timely return.

33 (b) This section shall become operative on ~~July 1, 2011~~ *January*
34 *1, 2014*.

35 *SEC. 30. Section 12305 of the Revenue and Taxation Code, as*
36 *amended by Section 57 of Chapter 717 of the Statutes of 2010, is*
37 *amended to read:*

38 12305. (a) The insurer or Medi-Cal managed care plan required
39 to file a return shall deliver the return in duplicate, together with
40 a remittance payable to the Controller, for the amount of tax

1 computed and shown thereon, less any prepayments made pursuant
2 to Article 5 (commencing with Section 12251) of Chapter 3 of this
3 part, to the office of the commissioner.

4 (b) This section shall become inoperative on ~~July 1, 2011~~
5 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ ~~July 1, 2014~~, is
6 repealed, unless a later enacted statute, that becomes operative on
7 or before ~~January 1, 2012~~ ~~July 1, 2014~~, deletes or extends the dates
8 on which it becomes inoperative and is repealed.

9 *SEC. 31. Section 12305 of the Revenue and Taxation Code, as*
10 *amended by Section 58 of Chapter 717 of the Statutes of 2010, is*
11 *amended to read:*

12 12305. (a) The insurer required to file a return shall deliver
13 the return in duplicate, together with a remittance payable to the
14 Controller, for the amount of tax computed and shown thereon,
15 less any prepayments made pursuant to Article 5 (commencing
16 with Section 12251) of Chapter 3 of this part, to the office of the
17 commissioner.

18 (b) This section shall become operative on ~~July 1, 2011~~ *January*
19 *1, 2014.*

20 *SEC. 32. Section 12307 of the Revenue and Taxation Code, as*
21 *amended by Section 59 of Chapter 717 of the Statutes of 2010, is*
22 *amended to read:*

23 12307. (a) Any insurer or Medi-Cal managed care plan to
24 which an extension is granted shall pay, in addition to the tax,
25 interest at the modified adjusted rate per month, or fraction thereof,
26 established pursuant to Section 6591.5, from April 1st until the
27 date of payment.

28 (b) This section shall become inoperative on ~~July 1, 2011~~
29 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ ~~July 1, 2014~~, is
30 repealed, unless a later enacted statute, that becomes operative on
31 or before ~~January 1, 2012~~ ~~July 1, 2014~~, deletes or extends the dates
32 on which it becomes inoperative and is repealed.

33 *SEC. 33. Section 12307 of the Revenue and Taxation Code, as*
34 *amended by Section 60 of Chapter 717 of the Statutes of 2010, is*
35 *amended to read:*

36 12307. (a) Any insurer that is granted an extension shall pay,
37 in addition to the tax, interest at the modified adjusted rate per
38 month, or fraction thereof, established pursuant to Section 6591.5,
39 from April 1st until the date of payment.

(b) This section shall become operative on ~~July 1, 2011~~ January 1, 2014.

SEC. 34. Section 12412 of the Revenue and Taxation Code, as amended by Section 61 of Chapter 717 of the Statutes of 2010, is amended to read:

12412. (a) Upon receipt of the duplicate copy of the return of an insurer or Medi-Cal managed care plan the board shall initially assess the tax in accordance with the data as reported by the insurer or Medi-Cal managed care plan on the return.

(b) This section shall become inoperative on ~~July 1, 2011~~ January 1, 2014, and, as of ~~January 1, 2012~~ July 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before ~~January 1, 2012~~ July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 35. Section 12412 of the Revenue and Taxation Code, as amended by Section 62 of Chapter 717 of the Statutes of 2010, is amended to read:

12412. (a) Upon receipt of the duplicate copy of the return of an insurer the board shall initially assess the tax in accordance with the data as reported by the insurer on the return.

(b) This section shall become operative on ~~July 1, 2011~~ January 1, 2014.

SEC. 36. Section 12413 of the Revenue and Taxation Code, as amended by Section 63 of Chapter 717 of the Statutes of 2010, is amended to read:

12413. (a) The board shall promptly transmit notice of its initial assessment to the commissioner and the Controller, and if the initial assessment differs from the amount computed by the insurer or Medi-Cal managed care plan, notice shall also be given to the insurer or Medi-Cal managed care plan.

(b) This section shall become inoperative on ~~July 1, 2011~~ January 1, 2014, and, as of ~~January 1, 2012~~ July 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before ~~January 1, 2012~~ July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 37. Section 12413 of the Revenue and Taxation Code, as amended by Section 64 of Chapter 717 of the Statutes of 2010, is amended to read:

12413. (a) The board shall promptly transmit notice of its initial assessment to the commissioner and the Controller, and if

1 the initial assessment differs from the amount computed by the
2 insurer, notice shall also be given to the insurer.

3 (b) This section shall become operative on ~~July 1, 2011~~ January
4 1, 2014.

5 *SEC. 38. Section 12421 of the Revenue and Taxation Code, as*
6 *amended by Section 65 of Chapter 717 of the Statutes of 2010, is*
7 *amended to read:*

8 12421. (a) As soon as practicable after an insurer's, surplus
9 line broker's, or Medi-Cal managed care plan's return is filed, the
10 commissioner shall examine it, together with any information
11 within his or her possession or that may come into his or her
12 possession, and he or she shall determine the correct amount of
13 tax of the insurer, surplus line broker, or Medi-Cal managed care
14 plan.

15 (b) This section shall become inoperative on ~~July 1, 2011~~
16 *January 1, 2014*, and, as of ~~January 1, 2012~~ July 1, 2014, is
17 repealed, unless a later enacted statute, that becomes operative on
18 or before ~~January 1, 2012~~ July 1, 2014, deletes or extends the dates
19 on which it becomes inoperative and is repealed.

20 *SEC. 39. Section 12421 of the Revenue and Taxation Code, as*
21 *amended by Section 66 of Chapter 717 of the Statutes of 2010, is*
22 *amended to read:*

23 12421. (a) As soon as practicable after an insurer's or surplus
24 line broker's return is filed, the commissioner shall examine it,
25 together with any information within his or her possession or that
26 may come into his or her possession, and he or she shall determine
27 the correct amount of tax of the insurer or surplus line broker.

28 (b) This section shall become operative on ~~July 1, 2011~~ January
29 1, 2014.

30 *SEC. 40. Section 12422 of the Revenue and Taxation Code, as*
31 *amended by Section 67 of Chapter 717 of the Statutes of 2010, is*
32 *amended to read:*

33 12422. (a) If the commissioner determines that the amount of
34 tax disclosed by the insurer's tax return and assessed by the board
35 is less than the amount of tax disclosed by his or her examination,
36 he or she shall propose, in writing, to the board a deficiency
37 assessment for the difference. The proposal shall set forth the basis
38 for the deficiency assessment and the details of its computation.

39 (b) If the commissioner determines that the amount of tax
40 disclosed by the surplus line broker's tax return is less than the

1 amount of tax disclosed by his or her examination, he or she shall
2 propose, in writing, to the board a deficiency assessment for the
3 difference. The proposal shall set forth the basis for the deficiency
4 assessment and the details of its computation.

5 (c) If the commissioner determines that the amount of tax
6 disclosed by the Medi-Cal managed care plan's tax return is less
7 than the amount of tax disclosed by his or her examination, he or
8 she shall propose, in writing, to the board a deficiency assessment
9 for the difference. The proposal shall set forth the basis for the
10 deficiency assessment and the details of its computation.

11 (d) This section shall become inoperative on ~~July 1, 2011~~
12 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
13 repealed, unless a later enacted statute, that becomes operative on
14 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
15 on which it becomes inoperative and is repealed.

16 *SEC. 41. Section 12422 of the Revenue and Taxation Code, as*
17 *amended by Section 68 of Chapter 717 of the Statutes of 2010, is*
18 *amended to read:*

19 12422. (a) If the commissioner determines that the amount of
20 tax disclosed by the insurer's tax return and assessed by the board
21 is less than the amount of tax disclosed by his or her examination,
22 he or she shall propose, in writing, to the board a deficiency
23 assessment for the difference. The proposal shall set forth the basis
24 for the deficiency assessment and the details of its computation.

25 (b) If the commissioner determines that the amount of tax
26 disclosed by the surplus line broker's tax return is less than the
27 amount of tax disclosed by his or her examination, he or she shall
28 propose, in writing, to the board a deficiency assessment for the
29 difference. The proposal shall set forth the basis for the deficiency
30 assessment and the details of its computation.

31 (c) This section shall become operative on ~~July 1, 2011~~ *January*
32 *1, 2014*.

33 *SEC. 42. Section 12423 of the Revenue and Taxation Code, as*
34 *amended by Section 69 of Chapter 717 of the Statutes of 2010, is*
35 *amended to read:*

36 12423. (a) If an insurer, surplus line broker, or Medi-Cal
37 managed care plan fails to file a return, the commissioner may
38 require a return by mailing notice to the insurer, surplus line broker,
39 or Medi-Cal managed care plan to file a return by a specified date
40 or he or she may without requiring a return, or upon no return

1 having been filed pursuant to the demand therefor, make an
2 estimate of the amount of tax due for the calendar year or years in
3 respect to which the insurer, surplus line broker, or Medi-Cal
4 managed care plan failed to file the return. The estimate shall be
5 made from any available information which is in the
6 commissioner's possession or may come into his or her possession,
7 and the commissioner shall propose, in writing, to the board a
8 deficiency assessment for the amount of the estimated tax. The
9 proposal shall set forth the basis of the estimate and the details of
10 the computation of the tax.

11 (b) This section shall become inoperative on ~~July 1, 2011~~
12 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
13 repealed, unless a later enacted statute, that becomes operative on
14 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
15 on which it becomes inoperative and is repealed.

16 *SEC. 43. Section 12423 of the Revenue and Taxation Code, as*
17 *amended by Section 70 of Chapter 717 of the Statutes of 2010, is*
18 *amended to read:*

19 12423. (a) If an insurer or surplus line broker fails to file a
20 return, the commissioner may require a return by mailing notice
21 to the insurer or surplus line broker to file a return by a specified
22 date or he or she may without requiring a return, or upon no return
23 having been filed pursuant to the demand therefor, make an
24 estimate of the amount of tax due for the calendar year or years in
25 respect to which the insurer or surplus line broker failed to file the
26 return. The estimate shall be made from any available information
27 which is in the commissioner's possession or may come into his
28 or her possession, and the commissioner shall propose, in writing,
29 to the board a deficiency assessment for the amount of the
30 estimated tax. The proposal shall set forth the basis of the estimate
31 and the details of the computation of the tax.

32 (b) This section shall become operative on ~~July 1, 2011~~ *January*
33 *1, 2014*.

34 *SEC. 44. Section 12427 of the Revenue and Taxation Code, as*
35 *amended by Section 71 of Chapter 717 of the Statutes of 2010, is*
36 *amended to read:*

37 12427. (a) The board shall promptly notify the insurer, surplus
38 line broker, or Medi-Cal managed care plan of a deficiency
39 assessment made against the insurer, surplus line broker, or
40 Medi-Cal managed care plan.

(b) This section shall become inoperative on ~~July 1, 2011~~
~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
repealed, unless a later enacted statute, that becomes operative on
or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
on which it becomes inoperative and is repealed.

*SEC. 45. Section 12427 of the Revenue and Taxation Code, as
amended by Section 72 of Chapter 717 of the Statutes of 2010, is
amended to read:*

12427. (a) The board shall promptly notify the insurer or
surplus line broker of a deficiency assessment made against the
insurer or surplus line broker.

(b) This section shall become operative on ~~July 1, 2011~~ *January
1, 2014*.

*SEC. 46. Section 12428 of the Revenue and Taxation Code, as
amended by Section 73 of Chapter 717 of the Statutes of 2010, is
amended to read:*

12428. (a) An insurer, surplus line broker, or Medi-Cal
managed care plan against which a deficiency assessment is made
under Section 12424 or 12425 may petition for redetermination
of the deficiency assessment within 30 days after service upon the
insurer, surplus line broker, or Medi-Cal managed care plan of the
notice thereof, by filing with the board a written petition setting
forth the grounds of objection to the deficiency assessment and
the correction sought. At the time the petition is filed with the
board, a copy of the petition shall be filed with the commissioner.

If a petition for redetermination is not filed within the period
prescribed by this section, the deficiency assessment becomes final
and due and payable at the expiration of that period.

(b) This section shall become inoperative on ~~July 1, 2011~~
~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
repealed, unless a later enacted statute, that becomes operative on
or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
on which it becomes inoperative and is repealed.

*SEC. 47. Section 12428 of the Revenue and Taxation Code, as
amended by Section 74 of Chapter 717 of the Statutes of 2010, is
amended to read:*

12428. (a) An insurer or surplus line broker against which a
deficiency assessment is made under Section 12424 or 12425 may
petition for redetermination of the deficiency assessment within
30 days after service upon the insurer or surplus line broker of the

1 notice thereof, by filing with the board a written petition setting
2 forth the grounds of objection to the deficiency assessment and
3 the correction sought. At the time the petition is filed with the
4 board, a copy of the petition shall be filed with the commissioner.

5 If a petition for redetermination is not filed within the period
6 prescribed by this section, the deficiency assessment becomes final
7 and due and payable at the expiration of that period.

8 (b) This section shall become operative on ~~July 1, 2011~~ *January*
9 *1, 2014*.

10 *SEC. 48. Section 12429 of the Revenue and Taxation Code, as*
11 *amended by Section 75 of Chapter 717 of the Statutes of 2010, is*
12 *amended to read:*

13 12429. (a) If a petition for redetermination of a deficiency
14 assessment is filed within the time allowed under Section 12428,
15 the board shall reconsider the deficiency assessment and, if the
16 insurer, surplus line broker, or Medi-Cal managed care plan has
17 so requested in the petition, shall grant an oral hearing for the
18 presentation of evidence and argument before the board or its
19 authorized representative. The board shall give the petitioner and
20 the commissioner at least 20 days' notice of the time and place of
21 hearing. The hearing may be continued from time to time as may
22 be necessary.

23 (b) This section shall become inoperative on ~~July 1, 2011~~
24 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
25 repealed, unless a later enacted statute, that becomes operative on
26 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
27 on which it becomes inoperative and is repealed.

28 *SEC. 49. Section 12429 of the Revenue and Taxation Code, as*
29 *amended by Section 76 of Chapter 717 of the Statutes of 2010, is*
30 *amended to read:*

31 12429. (a) If a petition for redetermination of a deficiency
32 assessment is filed within the time allowed under Section 12428,
33 the board shall reconsider the deficiency assessment and, if the
34 insurer or surplus line broker has so requested in the petition, shall
35 grant an oral hearing for the presentation of evidence and argument
36 before the board or its authorized representative. The board shall
37 give the petitioner and the commissioner at least 20 days' notice
38 of the time and place of hearing. The hearing may be continued
39 from time to time as may be necessary.

(b) This section shall become operative on ~~July 1, 2011~~ *January 1, 2014*.

SEC. 50. Section 12431 of the Revenue and Taxation Code, as amended by Section 77 of Chapter 717 of the Statutes of 2010, is amended to read:

12431. (a) The order or decision of the board upon a petition for redetermination of a deficiency assessment becomes final 30 days after service on the insurer, surplus line broker, or Medi-Cal managed care plan of a notice thereof, and any resulting deficiency assessment is due and payable at the time the order or decision becomes final.

(b) This section shall become inoperative on ~~July 1, 2011~~ *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is repealed, unless a later enacted statute, that becomes operative on or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 51. Section 12431 of the Revenue and Taxation Code, as amended by Section 78 of Chapter 717 of the Statutes of 2010, is amended to read:

12431. (a) The order or decision of the board upon a petition for redetermination of a deficiency assessment becomes final 30 days after service on the insurer or surplus line broker of a notice thereof, and any resulting deficiency assessment is due and payable at the time the order or decision becomes final.

(b) This section shall become operative on ~~July 1, 2011~~ *January 1, 2014*.

SEC. 52. Section 12433 of the Revenue and Taxation Code, as amended by Section 79 of Chapter 717 of the Statutes of 2010, is amended to read:

12433. (a) If before the expiration of the time prescribed in Section 12432 for giving of a notice of deficiency assessment the insurer, surplus line broker, or Medi-Cal managed care plan has consented in writing to the giving of the notice after that time, the notice may be given at any time prior to the expiration of the time agreed upon. The period so agreed upon may be extended by subsequent agreements in writing made before the expiration of the period previously agreed upon.

(b) This section shall become inoperative on ~~July 1, 2011~~ *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is repealed, unless a later enacted statute, that becomes operative on

1 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
2 on which it becomes inoperative and is repealed.

3 *SEC. 53. Section 12433 of the Revenue and Taxation Code, as*
4 *amended by Section 80 of Chapter 717 of the Statutes of 2010, is*
5 *amended to read:*

6 12433. (a) If before the expiration of the time prescribed in
7 Section 12432 for giving of a notice of deficiency assessment the
8 insurer or surplus line broker has consented in writing to the giving
9 of the notice after that time, the notice may be given at any time
10 prior to the expiration of the time agreed upon. The period so
11 agreed upon may be extended by subsequent agreements in writing
12 made before the expiration of the period previously agreed upon.

13 (b) This section shall become operative on ~~July 1, 2011~~ *January*
14 *1, 2014*.

15 *SEC. 54. Section 12434 of the Revenue and Taxation Code, as*
16 *amended by Section 81 of Chapter 717 of the Statutes of 2010, is*
17 *amended to read:*

18 12434. (a) Any notice required by this article shall be placed
19 in a sealed envelope, with postage paid, addressed to the insurer,
20 surplus line broker, or Medi-Cal managed care plan at its address
21 as it appears in the records of the commissioner or the board. The
22 giving of notice shall be deemed complete at the time of deposit
23 of the notice in the United States Post Office, or a mailbox, subpost
24 office, substation or mail chute or other facility regularly
25 maintained or provided by the United States Postal Service, without
26 extension of time for any reason. In lieu of mailing, a notice may
27 be served personally by delivering to the person to be served and
28 service shall be deemed complete at the time of the delivery.
29 Personal service to a corporation may be made by delivery of a
30 notice to any person designated in the Code of Civil Procedure to
31 be served for the corporation with summons and complaint in a
32 civil action.

33 (b) This section shall become inoperative on ~~July 1, 2011~~
34 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
35 repealed, unless a later enacted statute, that becomes operative on
36 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
37 on which it becomes inoperative and is repealed.

38 *SEC. 55. Section 12434 of the Revenue and Taxation Code, as*
39 *amended by Section 82 of Chapter 717 of the Statutes of 2010, is*
40 *amended to read:*

1 12434. (a) Any notice required by this article shall be placed
2 in a sealed envelope, with postage paid, addressed to the insurer
3 or surplus line broker at its address as it appears in the records of
4 the commissioner or the board. The giving of notice shall be
5 deemed complete at the time of deposit of the notice in the United
6 States Post Office, or a mailbox, subpost office, substation or mail
7 chute or other facility regularly maintained or provided by the
8 United States Postal Service, without extension of time for any
9 reason. In lieu of mailing, a notice may be served personally by
10 delivering to the person to be served and service shall be deemed
11 complete at the time of the delivery. Personal service to a
12 corporation may be made by delivery of a notice to any person
13 designated in the Code of Civil Procedure to be served for the
14 corporation with summons and complaint in a civil action.

15 (b) This section shall become operative on ~~July 1, 2011~~ *January*
16 *1, 2014*.

17 *SEC. 56. Section 12491 of the Revenue and Taxation Code, as*
18 *amended by Section 83 of Chapter 717 of the Statutes of 2010, is*
19 *amended to read:*

20 12491. (a) Every tax levied upon an insurer under Article XIII
21 of the California Constitution and this part is a lien upon all
22 property and franchises of every kind and nature belonging to the
23 insurer, and has the effect of a judgment against the insurer.

24 (b) (1) Every tax levied upon a surplus line broker under Part
25 7.5 (commencing with Section 13201) of Division 2 is a lien upon
26 all property and franchises of every kind and nature belonging to
27 the surplus line broker, and has the effect of a judgment against
28 the surplus line broker.

29 (2) A lien levied pursuant to this subdivision shall not exceed
30 the amount of unpaid tax collected by the surplus line broker.

31 (c) (1) Every tax levied upon a Medi-Cal managed care plan
32 under Chapter 1 (commencing with Section 12001) is a lien upon
33 all property and franchises of every kind and nature belonging to
34 the Medi-Cal managed care plan, and has the effect of a judgment
35 against the Medi-Cal managed care plan.

36 (2) A lien levied pursuant to this subdivision shall not exceed
37 the amount of unpaid tax collected by the Medi-Cal managed care
38 plan.

39 (d) This section shall become inoperative on ~~July 1, 2011~~
40 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is

1 repealed, unless a later enacted statute, that becomes operative on
2 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
3 on which it becomes inoperative and is repealed.

4 *SEC. 57. Section 12491 of the Revenue and Taxation Code, as*
5 *amended by Section 84 of Chapter 717 of the Statutes of 2010, is*
6 *amended to read:*

7 12491. (a) Every tax levied upon an insurer under the
8 provisions of Article XIII of the California Constitution and of
9 this part is a lien upon all property and franchises of every kind
10 and nature belonging to the insurer, and has the effect of a
11 judgment against the insurer.

12 (b) (1) Every tax levied upon a surplus line broker under the
13 provisions of Part 7.5 (commencing with Section 13201) of
14 Division 2 is a lien upon all property and franchises of every kind
15 and nature belonging to the surplus line broker, and has the effect
16 of a judgment against the surplus line broker.

17 (2) A lien levied pursuant to this subdivision shall not exceed
18 the amount of unpaid tax collected by the surplus line broker.

19 (c) This section shall become operative on ~~July 1, 2011~~ *January*
20 *1, 2014*.

21 *SEC. 58. Section 12493 of the Revenue and Taxation Code, as*
22 *amended by Section 85 of Chapter 717 of the Statutes of 2010, is*
23 *amended to read:*

24 12493. (a) Every lien has the effect of an execution duly levied
25 against all property of a delinquent insurer, surplus line broker, or
26 Medi-Cal managed care plan.

27 (b) This section shall become inoperative on ~~July 1, 2011~~
28 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
29 repealed, unless a later enacted statute, that becomes operative on
30 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
31 on which it becomes inoperative and is repealed.

32 *SEC. 59. Section 12493 of the Revenue and Taxation Code, as*
33 *amended by Section 86 of Chapter 717 of the Statutes of 2010, is*
34 *amended to read:*

35 12493. (a) Every lien has the effect of an execution duly levied
36 against all property of a delinquent insurer or surplus line broker.

37 (b) This section shall become operative on ~~July 1, 2011~~ *January*
38 *1, 2014*.

1 *SEC. 60. Section 12494 of the Revenue and Taxation Code, as*
2 *amended by Section 87 of Chapter 717 of the Statutes of 2010, is*
3 *amended to read:*

4 12494. (a) No judgment is satisfied nor lien removed until
5 either:

- 6 (1) The taxes, interest, penalties, and costs are paid.
7 (2) The insurer's, surplus line broker's, or Medi-Cal managed
8 care plan's property is sold for the payment thereof.

9 (b) This section shall become inoperative on ~~July 1, 2011~~
10 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
11 repealed, unless a later enacted statute, that becomes operative on
12 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
13 on which it becomes inoperative and is repealed.

14 *SEC. 61. Section 12494 of the Revenue and Taxation Code, as*
15 *amended by Section 88 of Chapter 717 of the Statutes of 2010, is*
16 *amended to read:*

17 12494. (a) No judgment is satisfied nor lien removed until
18 either:

- 19 (1) The taxes, interest, penalties, and costs are paid.
20 (2) The insurer's or surplus line broker's property is sold for
21 the payment thereof.

22 (b) This section shall become operative on ~~July 1, 2011~~ *January*
23 ~~1, 2014~~.

24 *SEC. 62. Section 12601 of the Revenue and Taxation Code, as*
25 *amended by Section 89 of Chapter 717 of the Statutes of 2010, is*
26 *amended to read:*

27 12601. (a) Amounts of taxes, interest, and penalties not
28 remitted to the commissioner with the original return of the insurer
29 or Medi-Cal managed care plan shall be payable to the Controller.

30 (b) This section shall become inoperative on ~~July 1, 2011~~
31 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
32 repealed, unless a later enacted statute, that becomes operative on
33 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
34 on which it becomes inoperative and is repealed.

35 *SEC. 63. Section 12601 of the Revenue and Taxation Code, as*
36 *amended by Section 90 of Chapter 717 of the Statutes of 2010, is*
37 *amended to read:*

38 12601. (a) Amounts of taxes, interest, and penalties not
39 remitted to the commissioner with the original return of the insurer
40 shall be payable to the Controller.

(b) This section shall become operative on ~~July 1, 2011~~ January 1, 2014.

SEC. 64. Section 12602 of the Revenue and Taxation Code, as amended by Section 91 of Chapter 717 of the Statutes of 2010, is amended to read:

12602. (a) (1) On and after January 1, 1994, and before January 1, 1995, each insurer whose annual taxes exceed fifty thousand dollars (\$50,000) shall make payment by electronic funds transfer, as defined by Section 45 of the Insurance Code. On and after January 1, 1995, each insurer whose annual taxes exceed twenty thousand dollars (\$20,000) shall make payment by electronic funds transfer. The insurer shall choose one of the acceptable methods described in Section 45 of the Insurance Code for completing the electronic funds transfer.

(2) Each Medi-Cal managed care plan shall make payment by electronic funds transfer, as defined by Section 45 of the Insurance Code. The plan shall choose one of the acceptable methods described in Section 45 of the Insurance Code for completing the electronic funds transfer.

(b) Payment shall be deemed complete on the date the electronic funds transfer is initiated, if settlement to the state's demand account occurs on or before the banking day following the date the transfer is initiated. If settlement to the state's demand account does not occur on or before the banking day following the date the transfer is initiated, payment shall be deemed to occur on the date settlement occurs.

(c) (1) Any insurer or Medi-Cal managed care plan required to remit taxes by electronic funds transfer pursuant to this section that remits those taxes by means other than an appropriate electronic funds transfer, shall be assessed a penalty in an amount equal to 10 percent of the taxes due at the time of the payment.

(2) If the Department of Insurance finds that an insurer's or Medi-Cal managed care plan's failure to make payment by an appropriate electronic funds transfer in accordance with subdivision (a) is due to reasonable cause or circumstances beyond the insurer's or Medi-Cal managed care plan's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, that insurer or Medi-Cal managed care plan shall be relieved of the penalty provided in paragraph (1).

1 (3) Any insurer or Medi-Cal managed care plan seeking to be
2 relieved of the penalty provided in paragraph (1) shall file with
3 the Department of Insurance a statement under penalty of perjury
4 setting forth the facts upon which the claim for relief is based.

5 (d) This section shall become inoperative on ~~July 1, 2011~~
6 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
7 repealed, unless a later enacted statute, that becomes operative on
8 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
9 on which it becomes inoperative and is repealed.

10 *SEC. 65. Section 12602 of the Revenue and Taxation Code, as*
11 *amended by Section 92 of Chapter 717 of the Statutes of 2010, is*
12 *amended to read:*

13 12602. (a) On and after January 1, 1994, and before January
14 1, 1995, each insurer whose annual taxes exceed fifty thousand
15 dollars (\$50,000) shall make payment by electronic funds transfer,
16 as defined by Section 45 of the Insurance Code. On and after
17 January 1, 1995, each insurer whose annual taxes exceed twenty
18 thousand dollars (\$20,000) shall make payment by electronic funds
19 transfer. The insurer shall choose one of the acceptable methods
20 described in Section 45 of the Insurance Code for completing the
21 electronic funds transfer.

22 (b) Payment shall be deemed complete on the date the electronic
23 funds transfer is initiated, if settlement to the state's demand
24 account occurs on or before the banking day following the date
25 the transfer is initiated. If settlement to the state's demand account
26 does not occur on or before the banking day following the date the
27 transfer is initiated, payment shall be deemed to occur on the date
28 settlement occurs.

29 (c) (1) Any insurer required to remit taxes by electronic funds
30 transfer pursuant to this section that remits those taxes by means
31 other than an appropriate electronic funds transfer, shall be assessed
32 a penalty in an amount equal to 10 percent of the taxes due at the
33 time of the payment.

34 (2) If the Department of Insurance finds that an insurer's failure
35 to make payment by an appropriate electronic funds transfer in
36 accordance with subdivision (a) is due to reasonable cause or
37 circumstances beyond the insurer's control, and occurred
38 notwithstanding the exercise of ordinary care and in the absence
39 of willful neglect, that insurer shall be relieved of the penalty
40 provided in paragraph (1).

(3) Any insurer seeking to be relieved of the penalty provided in paragraph (1) shall file with the Department of Insurance a statement under penalty of perjury setting forth the facts upon which the claim for relief is based.

(d) This section shall become operative on ~~July 1, 2011~~ January 1, 2014.

SEC. 66. Section 12631 of the Revenue and Taxation Code, as amended by Section 93 of Chapter 717 of the Statutes of 2010, is amended to read:

12631. (a) Any insurer or Medi-Cal managed care plan that fails to pay any tax, except a tax determined as a deficiency assessment by the board under Article 3 (commencing with Section 12421) of Chapter 4, within the time required, shall pay a penalty of 10 percent of the amount of the tax in addition to the tax, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the tax until the date of payment.

(b) This section shall become inoperative on ~~July 1, 2011~~ January 1, 2014, and, as of ~~January 1, 2012~~ July 1, 2014, is repealed, unless a later enacted statute, that becomes operative on or before ~~January 1, 2012~~ July 1, 2014, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 67. Section 12631 of the Revenue and Taxation Code, as amended by Section 94 of Chapter 717 of the Statutes of 2010, is amended to read:

12631. (a) Any insurer that fails to pay any tax, except a tax determined as a deficiency assessment by the board under Article 3 (commencing with Section 12421) of Chapter 4, within the time required, shall pay a penalty of 10 percent of the amount of the tax in addition to the tax, plus interest at the modified adjusted rate per month, or fraction thereof, established pursuant to Section 6591.5, from the due date of the tax until the date of payment.

(b) This section shall become operative on ~~July 1, 2011~~ January 1, 2014.

SEC. 68. Section 12632 of the Revenue and Taxation Code, as amended by Section 95 of Chapter 717 of the Statutes of 2010, is amended to read:

12632. (a) An insurer or Medi-Cal managed care plan that fails to pay any deficiency assessment when it becomes due and payable shall, in addition to the deficiency assessment, pay a

1 penalty of 10 percent of the amount of the deficiency assessment,
2 exclusive of interest and penalties. The amount of any deficiency
3 assessment, exclusive of penalties, shall bear interest at the
4 modified adjusted rate per month, or fraction thereof, established
5 pursuant to Section 6591.5, from the date on which the amount,
6 or any portion thereof, would have been payable if properly
7 reported and assessed until the date of payment.

8 (b) This section shall become inoperative on ~~July 1, 2011~~
9 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
10 repealed, unless a later enacted statute, that becomes operative on
11 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
12 on which it becomes inoperative and is repealed.

13 *SEC. 69. Section 12632 of the Revenue and Taxation Code, as*
14 *amended by Section 96 of Chapter 717 of the Statutes of 2010, is*
15 *amended to read:*

16 12632. (a) An insurer that fails to pay any deficiency
17 assessment when it becomes due and payable shall, in addition to
18 the deficiency assessment, pay a penalty of 10 percent of the
19 amount of the deficiency assessment, exclusive of interest and
20 penalties. The amount of any deficiency assessment, exclusive of
21 penalties, shall bear interest at the modified adjusted rate per
22 month, or fraction thereof, established pursuant to Section 6591.5,
23 from the date on which the amount, or any portion thereof, would
24 have been payable if properly reported and assessed until the date
25 of payment.

26 (b) This section shall become operative on ~~July 1, 2011~~ *January*
27 *1, 2014*.

28 *SEC. 70. Section 12636 of the Revenue and Taxation Code, as*
29 *amended by Section 97 of Chapter 717 of the Statutes of 2010, is*
30 *amended to read:*

31 12636. (a) If the board finds that an insurer's or Medi-Cal
32 managed care plan's failure to make a timely return or payment
33 is due to reasonable cause and to circumstances beyond the
34 insurer's or Medi-Cal managed care plan's control, and which
35 occurred despite the exercise of ordinary care and in the absence
36 of willful neglect, the insurer or Medi-Cal managed care plan may
37 be relieved of the penalty provided by Section 12258, 12282,
38 12287, 12631, 12632, or 12633.

39 Any insurer or Medi-Cal managed care plan seeking to be
40 relieved of the penalty shall file with the board a statement under

1 penalty of perjury setting forth the facts upon which the claim for
2 relief is based.

3 (b) This section shall become inoperative on ~~July 1, 2011~~
4 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
5 repealed, unless a later enacted statute, that becomes operative on
6 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
7 on which it becomes inoperative and is repealed.

8 *SEC. 71. Section 12636 of the Revenue and Taxation Code, as*
9 *amended by Section 98 of Chapter 717 of the Statutes of 2010, is*
10 *amended to read:*

11 12636. (a) If the board finds that an insurer's failure to make
12 a timely return or payment is due to reasonable cause and to
13 circumstances beyond the insurer's control, and which occurred
14 despite the exercise of ordinary care and in the absence of willful
15 neglect, the insurer may be relieved of the penalty provided by
16 Section 12258, 12282, 12287, 12631, 12632, or 12633.

17 Any insurer seeking to be relieved of the penalty shall file with
18 the board a statement under penalty of perjury setting forth the
19 facts upon which the claim for relief is based.

20 (b) This section shall become operative on ~~July 1, 2011~~ *January*
21 *1, 2014*.

22 *SEC. 72. Section 12636.5 of the Revenue and Taxation Code,*
23 *as amended by Section 99 of Chapter 717 of the Statutes of 2010,*
24 *is amended to read:*

25 12636.5. (a) Every payment on an insurer's, surplus line
26 broker's, or Medi-Cal managed care plan's delinquent annual tax
27 shall be applied as follows:

28 (1) First, to any interest due on the tax.

29 (2) Second, to any penalty imposed by this part.

30 (3) The balance, if any, to the tax itself.

31 (b) This section shall become inoperative on ~~July 1, 2011~~
32 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
33 repealed, unless a later enacted statute, that becomes operative on
34 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
35 on which it becomes inoperative and is repealed.

36 *SEC. 73. Section 12636.5 of the Revenue and Taxation Code,*
37 *as amended by Section 100 of Chapter 717 of the Statutes of 2010,*
38 *is amended to read:*

39 12636.5. (a) Every payment on an insurer's or surplus line
40 broker's delinquent annual tax shall be applied as follows:

1 (1) First, to any interest due on the tax.

2 (2) Second, to any penalty imposed by this part.

3 (3) The balance, if any, to the tax itself.

4 (b) This section shall become operative on ~~July 1, 2011~~ *January*
5 *1, 2014*.

6 *SEC. 74. Section 12679 of the Revenue and Taxation Code, as*
7 *amended by Section 101 of Chapter 717 of the Statutes of 2010,*
8 *is amended to read:*

9 12679. (a) If an insurer's or Medi-Cal managed care plan's
10 right to do business has been forfeited or its corporate powers
11 suspended, service of summons may be made upon the persons
12 designated by law to be served as agents or officers of the insurer
13 or Medi-Cal managed care plan, and these persons are the agents
14 of the insurer or Medi-Cal managed care plan for all purposes
15 necessary in order to prosecute the action. In the case of
16 corporations whose powers have been suspended, the persons
17 constituting the board of directors may defend the action.

18 (b) This section shall become inoperative on ~~July 1, 2011~~
19 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
20 repealed, unless a later enacted statute, that becomes operative on
21 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
22 on which it becomes inoperative and is repealed.

23 *SEC. 75. Section 12679 of the Revenue and Taxation Code, as*
24 *amended by Section 102 of Chapter 717 of the Statutes of 2010,*
25 *is amended to read:*

26 12679. (a) If an insurer's right to do business has been forfeited
27 or its corporate powers suspended, service of summons may be
28 made upon the persons designated by law to be served as agents
29 or officers of the insurer, and these persons are the agents of the
30 insurer for all purposes necessary in order to prosecute the action.
31 In the case of corporations whose powers have been suspended,
32 the persons constituting the board of directors may defend the
33 action.

34 (b) This section shall become operative on ~~July 1, 2011~~ *January*
35 *1, 2014*.

36 *SEC. 76. Section 12681 of the Revenue and Taxation Code, as*
37 *amended by Section 103 of Chapter 717 of the Statutes of 2010,*
38 *is amended to read:*

1 12681. (a) In the action, a certificate of the Controller or of
2 the secretary of the board, showing unpaid taxes against an insurer
3 or Medi-Cal managed care plan is prima facie evidence of:

- 4 (1) The assessment of the taxes.
5 (2) The delinquency.
6 (3) The amount of the taxes, interest, and penalties due and
7 unpaid to the state.
8 (4) That the insurer or Medi-Cal managed care plan is indebted
9 to the state in the amount of taxes, interest, and penalties appearing
10 unpaid.

11 (5) That there has been compliance with all the requirements
12 of law in relation to the assessment of the taxes.

13 (b) This section shall become inoperative on ~~July 1, 2011~~
14 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
15 repealed, unless a later enacted statute, that becomes operative on
16 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
17 on which it becomes inoperative and is repealed.

18 *SEC. 77. Section 12681 of the Revenue and Taxation Code, as*
19 *amended by Section 104 of Chapter 717 of the Statutes of 2010,*
20 *is amended to read:*

21 12681. (a) In the action, a certificate of the Controller or of
22 the secretary of the board, showing unpaid taxes against an insurer
23 is prima facie evidence of:

- 24 (1) The assessment of the taxes.
25 (2) The delinquency.
26 (3) The amount of the taxes, interest, and penalties due and
27 unpaid to the state.
28 (4) That the insurer is indebted to the state in the amount of
29 taxes, interest, and penalties appearing unpaid.
30 (5) That there has been compliance with all the requirements
31 of law in relation to the assessment of the taxes.

32 (b) This section shall become operative on ~~July 1, 2011~~ *January*
33 *1, 2014*.

34 *SEC. 78. Section 12801 of the Revenue and Taxation Code, as*
35 *amended by Section 105 of Chapter 717 of the Statutes of 2010,*
36 *is amended to read:*

37 12801. (a) Annually, between December 10th and 15th, the
38 Controller shall transmit to the commissioner a statement showing
39 the names of all insurers and Medi-Cal managed care plans that
40 failed to pay on or before December 10th the whole or any portion

1 of the tax that became delinquent in the preceding June or which
2 has been unpaid for more than 30 days from the date it became
3 due and payable as a deficiency assessment under this part or the
4 whole or any part of the interest or penalties due with respect to
5 the tax. The statement shall show the amount of the tax, interest,
6 and penalties due from each insurer or Medi-Cal managed care
7 plan.

8 (b) This section shall become inoperative on ~~July 1, 2011~~
9 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
10 repealed, unless a later enacted statute, that becomes operative on
11 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
12 on which it becomes inoperative and is repealed.

13 *SEC. 79. Section 12801 of the Revenue and Taxation Code, as*
14 *amended by Section 106 of Chapter 717 of the Statutes of 2010,*
15 *is amended to read:*

16 12801. (a) Annually, between December 10th and 15th, the
17 Controller shall transmit to the commissioner a statement showing
18 the names of all insurers that failed to pay on or before December
19 10th the whole or any portion of the tax that became delinquent
20 in the preceding June or which has been unpaid for more than 30
21 days from the date it became due and payable as a deficiency
22 assessment under this part or the whole or any part of the interest
23 or penalties due with respect to the tax. The statement shall show
24 the amount of the tax, interest, and penalties due from each insurer.

25 (b) This section shall become operative on ~~July 1, 2011~~ *January*
26 *1, 2014*.

27 *SEC. 80. Section 12951 of the Revenue and Taxation Code, as*
28 *amended by Section 107 of Chapter 717 of the Statutes of 2010,*
29 *is amended to read:*

30 12951. (a) If any amount has been illegally assessed, the board
31 shall set forth that fact in its records, certify the amount determined
32 to be assessed in excess of the amount legally assessed and the
33 insurer, surplus line broker, or Medi-Cal managed care plan against
34 which the assessment was made, and authorize the cancellation of
35 the amount upon the records of the Controller and the board. The
36 board shall mail a notice to the insurer, surplus line broker, or
37 Medi-Cal managed care plan of any cancellation authorized. Any
38 proposed determination by the board pursuant to this section with
39 respect to an amount in excess of fifty thousand dollars (\$50,000)

1 shall be available as a public record for at least 10 days prior to
2 the effective date of that determination.

3 (b) This section shall become inoperative on ~~July 1, 2011~~
4 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
5 repealed, unless a later enacted statute, that becomes operative on
6 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
7 on which it becomes inoperative and is repealed.

8 *SEC. 81. Section 12951 of the Revenue and Taxation Code, as*
9 *amended by Section 108 of Chapter 717 of the Statutes of 2010,*
10 *is amended to read:*

11 12951. (a) If any amount has been illegally assessed, the board
12 shall set forth that fact in its records, certify the amount determined
13 to be assessed in excess of the amount legally assessed and the
14 insurer or surplus line broker against which the assessment was
15 made, and authorize the cancellation of the amount upon the
16 records of the Controller and the board. The board shall mail a
17 notice to the insurer or surplus line broker of any cancellation
18 authorized. Any proposed determination by the board pursuant to
19 this section with respect to an amount in excess of fifty thousand
20 dollars (\$50,000) shall be available as a public record for at least
21 10 days prior to the effective date of that determination.

22 (b) This section shall become operative on ~~July 1, 2011~~ *January*
23 *1, 2014*.

24 *SEC. 82. Section 12977 of the Revenue and Taxation Code, as*
25 *amended by Section 109 of Chapter 717 of the Statutes of 2010,*
26 *is amended to read:*

27 12977. (a) If the board determines that any tax, interest, or
28 penalty has been paid more than once or has been erroneously or
29 illegally collected or computed, the board shall set forth that fact
30 in its records of the board, certify the amount of the taxes, interest,
31 or penalties collected in excess of what was legally due, and from
32 whom they were collected or by whom paid, and certify the excess
33 to the Controller for credit or refund.

34 (b) The Controller upon receipt of a certification for credit or
35 refund shall credit the excess on any amounts then due and payable
36 from the insurer, surplus line broker, or Medi-Cal managed care
37 plan under this part and refund the balance.

38 (c) Any proposed determination by the board pursuant to this
39 section with respect to an amount in excess of fifty thousand dollars

1 (\$50,000) shall be available as a public record for at least 10 days
2 prior to the effective date of that determination.

3 (d) This section shall become inoperative on ~~July 1, 2011~~
4 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
5 repealed, unless a later enacted statute, that becomes operative on
6 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
7 on which it becomes inoperative and is repealed.

8 *SEC. 83. Section 12977 of the Revenue and Taxation Code, as*
9 *amended by Section 110 of Chapter 717 of the Statutes of 2010,*
10 *is amended to read:*

11 12977. (a) If the board determines that any tax, interest, or
12 penalty has been paid more than once or has been erroneously or
13 illegally collected or computed, the board shall set forth that fact
14 in its records of the board, certify the amount of the taxes, interest,
15 or penalties collected in excess of what was legally due, and from
16 whom they were collected or by whom paid, and certify the excess
17 to the Controller for credit or refund.

18 (b) The Controller upon receipt of a certification for credit or
19 refund shall credit the excess on any amounts then due and payable
20 from the insurer or surplus line broker under this part and refund
21 the balance.

22 (c) Any proposed determination by the board pursuant to this
23 section with respect to an amount in excess of fifty thousand dollars
24 (\$50,000) shall be available as a public record for at least 10 days
25 prior to the effective date of that determination.

26 (d) This section shall become operative on ~~July 1, 2011~~ *January*
27 *1, 2014*.

28 *SEC. 84. Section 12983 of the Revenue and Taxation Code, as*
29 *amended by Section 111 of Chapter 717 of the Statutes of 2010,*
30 *is amended to read:*

31 12983. (a) Interest shall be allowed upon the amount of any
32 overpayment of tax by an insurer or Medi-Cal managed care plan
33 pursuant to this part at the modified adjusted rate per month
34 established pursuant to Section 6591.5, from the first day of the
35 monthly period following the period during which the overpayment
36 was made. For purposes of this section, "monthly period" means
37 the month commencing on the day after the due date of the payment
38 through the same date as the due date in each successive month.
39 In addition, a refund or credit shall be made of any interest imposed

1 upon the claimant with respect to the amount being refunded or
2 credited.

3 The interest shall be paid as follows:

4 (1) In the case of a refund, to the last day of the calendar month
5 following the date upon which the claimant is notified in writing
6 that a claim may be filed or the date upon which the claim is
7 approved by the board, whichever date is the earlier.

8 (2) In the case of a credit, to the same date as that to which
9 interest is computed on the tax or amount against which the credit
10 is applied.

11 (b) This section shall become inoperative on ~~July 1, 2011~~
12 *January 1, 2014*, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
13 repealed, unless a later enacted statute, that becomes operative on
14 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
15 on which it becomes inoperative and is repealed.

16 *SEC. 85. Section 12983 of the Revenue and Taxation Code, as*
17 *amended by Section 112 of Chapter 717 of the Statutes of 2010,*
18 *is amended to read:*

19 12983. (a) Interest shall be allowed upon the amount of any
20 overpayment of tax by an insurer pursuant to this part at the
21 modified adjusted rate per month established pursuant to Section
22 6591.5, from the first day of the monthly period following the
23 period during which the overpayment was made. For purposes of
24 this section, “monthly period” means the month commencing on
25 the day after the due date of the payment through the same date
26 as the due date in each successive month. In addition, a refund or
27 credit shall be made of any interest imposed upon the claimant
28 with respect to the amount being refunded or credited.

29 The interest shall be paid as follows:

30 (1) In the case of a refund, to the last day of the calendar month
31 following the date upon which the claimant is notified in writing
32 that a claim may be filed or the date upon which the claim is
33 approved by the board, whichever date is the earlier.

34 (2) In the case of a credit, to the same date as that to which
35 interest is computed on the tax or amount against which the credit
36 is applied.

37 (b) This section shall become operative on ~~July 1, 2011~~ *January*
38 *1, 2014*.

1 *SEC. 86. Section 12984 of the Revenue and Taxation Code, as*
2 *amended by Section 113 of Chapter 717 of the Statutes of 2010,*
3 *is amended to read:*

4 12984. (a) If the board determines that any overpayment has
5 been made intentionally or made not incident to a bona fide and
6 orderly discharge of a liability reasonably assumed by the insurer,
7 surplus line broker, or Medi-Cal managed care plan to be imposed
8 by law, no interest shall be allowed on the overpayment.

9 (b) If any insurer, surplus line broker, or Medi-Cal managed
10 care plan which has filed a claim for refund requests the board to
11 defer action on its claim, the board, as a condition to deferring
12 action, may require the claimant to waive interest for the period
13 during which the insurer, surplus line broker, or Medi-Cal managed
14 care plan requests the board to defer action on the claim.

15 (c) This section shall become inoperative on ~~July 1, 2011~~
16 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
17 repealed, unless a later enacted statute, that becomes operative on
18 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
19 on which it becomes inoperative and is repealed.

20 *SEC. 87. Section 12984 of the Revenue and Taxation Code, as*
21 *amended by Section 114 of Chapter 717 of the Statutes of 2010,*
22 *is amended to read:*

23 12984. (a) If the board determines that any overpayment has
24 been made intentionally or made not incident to a bona fide and
25 orderly discharge of a liability reasonably assumed by the insurer
26 or surplus line broker to be imposed by law, no interest shall be
27 allowed on the overpayment.

28 (b) If any insurer or surplus line broker which has filed a claim
29 for refund requests the board to defer action on its claim, the board,
30 as a condition to deferring action, may require the claimant to
31 waive interest for the period during which the insurer or surplus
32 line broker requests the board to defer action on the claim.

33 (c) This section shall become operative on ~~July 1, 2011~~ *January*
34 ~~1, 2014~~.

35 *SEC. 88. Section 13108 of the Revenue and Taxation Code, as*
36 *amended by Section 115 of Chapter 717 of the Statutes of 2010,*
37 *is amended to read:*

38 13108. (a) A judgment shall not be rendered in favor of the
39 plaintiff when the action is brought by or in the name of an assignee
40 of the insurer paying the tax, interest, or penalties, or by any person

1 other than the insurer or Medi-Cal managed care plan that has paid
2 the tax, interest, or penalties.

3 (b) This section shall become inoperative on ~~July 1, 2011~~
4 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
5 repealed, unless a later enacted statute, that becomes operative on
6 or before ~~January 1, 2012~~ *July 1, 2014*, deletes or extends the dates
7 on which it becomes inoperative and is repealed.

8 *SEC. 89. Section 13108 of the Revenue and Taxation Code, as*
9 *amended by Section 116 of Chapter 717 of the Statutes of 2010,*
10 *is amended to read:*

11 13108. (a) A judgment shall not be rendered in favor of the
12 plaintiff when the action is brought by or in the name of an assignee
13 of the insurer paying the tax, interest, or penalties, or by any person
14 other than the insurer that has paid the tax, interest, or penalties.

15 (b) This section shall become operative on ~~July 1, 2011~~ *January*
16 *1, 2014*.

17 *SEC. 89.2. Section 42007 of the Vehicle Code, as amended by*
18 *Section 37 of Chapter 720 of the Statutes of 2010, is amended to*
19 *read:*

20 42007. (a) (1) The clerk of the court shall collect a fee from
21 every person who is ordered or permitted to attend a traffic violator
22 school pursuant to Section 42005 or who attends any other
23 court-supervised program of traffic safety instruction. The fee shall
24 be in an amount equal to the total bail set forth for the eligible
25 offense on the uniform countywide bail schedule. As used in this
26 subdivision, “total bail” means the amount established pursuant
27 to Section 1269b of the Penal Code in accordance with the Uniform
28 Statewide Bail Schedule adopted by the Judicial Council, including
29 all assessments, surcharges, and penalty amounts. Where multiple
30 offenses are charged in a single notice to appear, the “total bail”
31 is the amount applicable for the greater of the qualifying offenses.
32 However, the court may determine a lesser fee under this
33 subdivision upon a showing that the defendant is unable to pay
34 the full amount.

35 The fee shall not include the cost, or any part thereof, of traffic
36 safety instruction offered by the school or other program.

37 (2) The clerk may accept from a defendant who is ordered or
38 permitted to attend traffic violator school a payment of at least 10
39 percent of the fee required by paragraph (1) upon filing a written
40 agreement by the defendant to pay the remainder of the fee

1 according to an installment payment schedule of no more than 90
2 days as agreed upon with the court. The Judicial Council shall
3 prescribe the form of the agreement for payment of the fee in
4 installments. When the defendant signs the Judicial Council form
5 for payment of the fee in installments, the court shall continue the
6 case to the date in the agreement to complete payment of the fee
7 and submit the certificate of completion of traffic violator school
8 to the court. The clerk shall collect a fee of up to thirty-five dollars
9 (\$35) to cover administrative and clerical costs for processing an
10 installment payment of the traffic violator school fee under this
11 paragraph.

12 (3) When a defendant fails to make an installment payment of
13 the fee according to an installment agreement, the court may
14 convert the fee to bail, declare it forfeited, and report the forfeiture
15 as a conviction under Section 1803. The court may also charge a
16 failure to pay under Section 40508 and impose a civil assessment
17 as provided in Section 1214.1 of the Penal Code or issue an arrest
18 warrant for a failure to pay. For the purposes of reporting a
19 conviction under this subdivision to the department under Section
20 1803, the date that the court declares the bail forfeited shall be
21 reported as the date of conviction.

22 (b) ~~Revenues—~~*Except as provided in subparagraph (B) of*
23 *paragraph (2), revenues* derived from the fee collected under this
24 section shall be deposited in accordance with Section 68084 of the
25 Government Code in the general fund of the county and, as may
26 be applicable, distributed as follows:

27 (1) In any county in which a fund is established pursuant to
28 Section 76100 or 76101 of the Government Code, the sum of one
29 dollar (\$1) for each fund so established shall be deposited with the
30 county treasurer and placed in that fund.

31 (2) (A) In any county that has established a Maddy Emergency
32 Medical Services Fund pursuant to Section 1797.98a of the Health
33 and Safety Code, an amount equal to the sum of each two dollars
34 (\$2) for every seven dollars (\$7) that would have been collected
35 pursuant to Section 76000 of the Government Code ~~and,~~
36 ~~commencing~~ *shall be deposited in that fund. Commencing* January
37 1, 2009, *and until June 30, 2011,* an amount equal to the sum of
38 each two dollars (\$2) for every ten dollars (\$10) that would have
39 been collected pursuant to Section 76000.5 of the Government

1 Code with respect to those counties to which that section is
2 applicable shall be deposited in that fund. ~~Nothing~~

3 *(B) On and after July 1, 2011, in every county, an amount equal*
4 *to the sum of two dollars (\$2) for every ten dollars (\$10) that would*
5 *have been collected pursuant to Section 76000.5 of the Government*
6 *Code if the defendant had not been ordered or permitted to attend*
7 *a traffic violator school shall be deposited in the State Emergency*
8 *Services Fund established pursuant to that section. This*
9 *subparagraph shall become inoperative on July 1, 2016.*

10 *(C) Nothing* in the act that added this paragraph shall be
11 interpreted in a manner that would result in either of the following:

12 ~~(A)~~

13 *(i) The utilization of penalty assessment funds that had been set*
14 *aside, on or before January 1, 2000, to finance debt service on a*
15 *capital facility that existed before January 1, 2000.*

16 ~~(B)~~

17 *(ii) The reduction of the availability of penalty assessment*
18 *revenues that had been pledged, on or before January 1, 2000, as*
19 *a means of financing a facility which was approved by a county*
20 *board of supervisors, but on January 1, 2000, is not under*
21 *construction.*

22 ~~(3)~~

23 *(iii) The amount of the fee that is attributable to Section 70372*
24 *of the Government Code shall be transferred pursuant to*
25 *subdivision (f) of that section.*

26 *(c) For fees resulting from city arrests, an amount equal to the*
27 *amount of base fines that would have been deposited in the treasury*
28 *of the appropriate city pursuant to paragraph (3) of subdivision*
29 *(b) of Section 1463.001 of the Penal Code shall be deposited in*
30 *the treasury of the appropriate city.*

31 *(d) As used in this section, "court-supervised program" includes,*
32 *but is not limited to, any program of traffic safety instruction the*
33 *successful completion of which is accepted by the court in lieu of*
34 *adjudicating a violation of this code.*

35 *(e) The clerk of the court, in a county that offers traffic school*
36 *shall include in any courtesy notice mailed to a defendant for an*
37 *offense that qualifies for traffic school attendance the following*
38 *statement:*

39

1 NOTICE: If you are eligible and decide not to attend traffic
2 school your automobile insurance may be adversely affected.

3
4 (f) Notwithstanding any other ~~provision of~~ law, a county that
5 has established a Maddy Emergency Medical Services Fund
6 pursuant to Section 1797.98a of the Health and Safety Code shall
7 not be held liable for having deposited into the fund, prior to
8 January 1, 2009, an amount equal to two dollars (\$2) for every ten
9 dollars (\$10) that would have been collected pursuant to Section
10 76000.5 of the Government Code from revenues derived from
11 traffic violator school fees collected pursuant to this section.

12 *SEC. 89.3. Section 42007 of the Vehicle Code, as added by*
13 *Section 16.5 of Chapter 599 of the Statutes of 2010, is amended*
14 *to read:*

15 42007. (a) (1) The clerk of the court shall collect from every
16 person who is ordered or permitted to attend a traffic violator
17 school pursuant to Section 41501 or 42005 an amount equal to the
18 total bail set forth for the eligible offense on the uniform
19 countywide bail schedule. As used in this subdivision, "total bail"
20 means the amount established pursuant to Section 1269b of the
21 Penal Code in accordance with the Uniform Statewide Bail
22 Schedule adopted by the Judicial Council, including all
23 assessments, surcharges, and penalty amounts. If multiple offenses
24 are charged in a single notice to appear, the "total bail" is the
25 amount applicable for the greater of the qualifying offenses.
26 However, the court may determine a lesser fee under this
27 subdivision upon a showing that the defendant is unable to pay
28 the full amount. The fee shall not include the cost, or any part
29 thereof, of traffic safety instruction offered by a traffic violator
30 school.

31 (2) The clerk may accept from a defendant who is ordered or
32 permitted to attend traffic violator school a payment of at least 25
33 percent of the fee required by paragraph (1) upon filing a written
34 agreement by the defendant to pay the remainder of the fee
35 according to an installment payment schedule of no more than 90
36 days as agreed upon with the court. The Judicial Council shall
37 prescribe the form of the agreement for payment of the fee in
38 installments. If the defendant signs the Judicial Council form for
39 payment of the fee in installments, the court shall continue the
40 case to the date in the agreement to complete payment of the fee

1 and submit the certificate of completion of traffic violator school
2 to the court. The clerk shall collect a fee of up to thirty-five dollars
3 (\$35) to cover the cost of processing an installment payment of
4 the traffic violator school fee under this paragraph.

5 (3) If a defendant fails to make an installment payment of the
6 fee according to an installment agreement, the court may convert
7 the fee to bail, declare it forfeited, and report the forfeiture as a
8 conviction under Section 1803. The court may also charge a failure
9 to pay under Section 40508 and impose a civil assessment as
10 provided in Section 1214.1 of the Penal Code or issue an arrest
11 warrant for a failure to pay.

12 (b) ~~Revenues~~—*Except as provided in subparagraph (B) of*
13 *paragraph (2), revenues* derived from the fee collected under this
14 section shall be deposited in accordance with Section 68084 of the
15 Government Code in the general fund of the county and, as may
16 be applicable, distributed as follows:

17 (1) In any county in which a fund is established pursuant to
18 Section 76100 or 76101 of the Government Code, the sum of one
19 dollar (\$1) for each fund so established shall be deposited with the
20 county treasurer and placed in that fund.

21 (2) (A) In any county that has established a Maddy Emergency
22 Medical Services Fund pursuant to Section 1797.98a of the Health
23 and Safety Code, an amount equal to the sum of each two dollars
24 (\$2) for every seven dollars (\$7) that would have been collected
25 pursuant to Section 76000 of the Government Code—~~and,~~
26 ~~commencing~~ *shall be deposited in that fund. Commencing* January
27 1, 2009, *and until June 30, 2011,* an amount equal to the sum of
28 each two dollars (\$2) for every ten dollars (\$10) that would have
29 been collected pursuant to Section 76000.5 of the Government
30 Code with respect to those counties to which that section is
31 applicable shall be deposited in that fund. ~~Nothing~~

32 (B) *On and after July 1, 2011, in every county, an amount equal*
33 *to the sum of two dollars (\$2) for every ten dollars (\$10) that would*
34 *have been collected pursuant to Section 76000.5 of the Government*
35 *Code if the defendant had not been ordered or permitted to attend*
36 *a traffic violator school shall be deposited in the State Emergency*
37 *Services Fund established pursuant to that section. This*
38 *subparagraph shall become inoperative on July 1, 2016.*

39 (C) *Nothing* in the act that added this paragraph shall be
40 interpreted in a manner that would result in either of the following:

1 ~~(A)~~

2 (i) The utilization of penalty assessment funds that had been set
3 aside, on or before January 1, 2000, to finance debt service on a
4 capital facility that existed before January 1, 2000.

5 ~~(B)~~

6 (ii) The reduction of the availability of penalty assessment
7 revenues that had been pledged, on or before January 1, 2000, as
8 a means of financing a facility that was approved by a county board
9 of supervisors, but on January 1, 2000, is not under construction.

10 ~~(3)~~

11 (iii) The amount of the fee that is attributable to Section 70372
12 of the Government Code shall be transferred pursuant to
13 subdivision (f) of that section.

14 (c) For fees resulting from city arrests, an amount equal to the
15 amount of base fines that would have been deposited in the treasury
16 of the appropriate city pursuant to paragraph (3) of subdivision
17 (b) of Section 1463.001 of the Penal Code shall be deposited in
18 the treasury of the appropriate city.

19 (d) The clerk of the court, in a county that offers traffic school
20 shall include in any courtesy notice mailed to a defendant for an
21 offense that qualifies for traffic school attendance the following
22 statement:

23
24 NOTICE: If you are eligible and decide not to attend traffic
25 school your automobile insurance may be adversely affected. One
26 conviction in any 18-month period will be held confidential and
27 not show on your driving record if you complete a traffic violator
28 school program.

29
30 (e) Notwithstanding any other ~~provision of~~ law, a county that
31 has established a Maddy Emergency Medical Services Fund
32 pursuant to Section 1797.98a of the Health and Safety Code shall
33 not be held liable for having deposited into the fund, prior to
34 January 1, 2009, an amount equal to two dollars (\$2) for every ten
35 dollars (\$10) that would have been collected pursuant to Section
36 76000.5 of the Government Code from revenues derived from
37 traffic violator school fees collected pursuant to this section.

38 (f) This section shall become operative on July 1, 2011.

39 *SEC. 89.4. Section 42007.3 of the Vehicle Code is amended to*
40 *read:*

1 42007.3. (a) Notwithstanding Section 42007, revenues derived
2 from fees collected under Section 42007, *except subparagraph*
3 *(B) of paragraph (2) of subdivision (b) of that section*, from each
4 person required or permitted to attend traffic violator school
5 pursuant to Section 41501 or 42005 as a result of a violation of
6 subdivision (a) or (c) of Section 21453, subdivision (c) of Section
7 21454, or subdivision (a) of Section 21457 shall be allocated as
8 follows:

9 (1) The first 30 percent of the amount collected shall be allocated
10 to the general fund of the city or county in which the offense
11 occurred.

12 (2) The balance of the amount collected shall be deposited by
13 the county treasurer under Section 42007.

14 (b) This section does not apply to the additional forty-nine-dollar
15 (\$49) court administrative fee assessed pursuant to subdivision (c)
16 of Section 11208 collected under subdivision (a) of Section
17 42007.1.

18 *SEC. 89.5. Section 42007.4 of the Vehicle Code is amended to*
19 *read:*

20 42007.4. (a) Notwithstanding Section 42007, *except*
21 *subparagraph (B) of paragraph (2) of subdivision (b) of that*
22 *section*, revenues derived from fees collected under Section 42007
23 from each person required or permitted to attend traffic violator
24 school pursuant to Section 369b of the Penal Code as a result of
25 a violation of subdivision (c) of Section 21752, involving railroad
26 grade crossings, or Section 22451 or 22452 shall be allocated as
27 follows:

28 (1) If the offense occurred in an area where a transit district or
29 transportation commission established under Division 12
30 (commencing with Section 130000) of the Public Utilities Code
31 provides rail transportation, the first 30 percent of the amount
32 collected shall be allocated to the general fund of that transit district
33 or transportation commission to be used only for public safety and
34 public education purposes relating to railroad grade crossings.

35 (2) If there is no transit district or transportation commission
36 providing rail transportation in the area where the offense occurred,
37 the first 30 percent of the amount collected shall be allocated to
38 the general fund of the county in which the offense occurred, to
39 be used only for public safety and public education purposes
40 relating to railroad grade crossings.

1 (3) The balance of the amount collected shall be deposited by
2 the county treasurer under Section 1463 of the Penal Code.

3 (4) A transit district, transportation commission, or a county
4 that is allocated funds pursuant to paragraph (1) or (2) shall provide
5 public safety and public education relating to railroad grade
6 crossings only to the extent that those purposes are funded by the
7 allocations provided pursuant to paragraph (1) or (2).

8 (b) This section does not apply to the additional forty-nine-dollar
9 (\$49) court administrative fee assessed pursuant to subdivision (c)
10 of Section 11208 collected under subdivision (a) of Section
11 42007.1.

12 *SEC. 89.6. Section 42008.7 of the Vehicle Code is amended to*
13 *read:*

14 42008.7. (a) The State of California continues to face a fiscal
15 and economic crisis affecting the state budget and the overall state
16 economy. In light of this crisis, a one-time infraction amnesty
17 program would do the following:

18 (1) Provide relief to individuals who have found themselves in
19 violation of a court-ordered obligation because they are financially
20 unable to pay traffic bail or fines.

21 (2) Provide increased revenue at a time when revenue is scarce
22 by encouraging payment of old fines that have remained unpaid.

23 (3) Allow courts and counties to resolve older delinquent cases
24 and focus limited resources on collecting on more recent cases.

25 (b) A one-time amnesty program for fines and bail meeting the
26 eligibility requirements set forth in subdivision (d) shall be
27 established in each county. Unless agreed otherwise by the court
28 and the county in writing, the government entities that are
29 responsible for the collection of delinquent court-ordered debt
30 shall be responsible for implementation of the amnesty program
31 as to that debt, maintaining the same division of responsibility in
32 place with respect to the collection of court-ordered debt under
33 subdivision (b) of Section 1463.010 of the Penal Code.

34 (c) As used in this section, the term “fine” or “bail” refers to
35 the total amounts due in connection with a specific violation, which
36 include, but are not limited to, the following:

37 (1) Base fine or bail, as established by court order, by statute,
38 or by the court’s bail schedule.

39 (2) Penalty assessments imposed pursuant to Section 1464 of
40 the Penal Code and Sections 76000, 70372, 76104.6, and 76104.7;

1 ~~and 76000.5~~ of the Government Code. *A penalty assessment*
2 *imposed pursuant to Section 76000.5 shall not be considered for*
3 *amnesty pursuant to this section.*

4 (3) Civil assessment imposed pursuant to Section 1214.1 of the
5 Penal Code.

6 (4) State surcharge imposed pursuant to Section 1465.7 of the
7 Penal Code.

8 (5) Court security fee imposed pursuant to Section 1465.8 of
9 the Penal Code.

10 (d) Violations are only eligible for amnesty if all of the following
11 requirements are met:

12 (1) The violation is an infraction violation filed with the court.

13 (2) The due date for payment of the fine or bail was on or before
14 January 1, 2009.

15 (3) The defendant does not owe victim restitution on any case
16 within the county.

17 (4) There are no outstanding misdemeanor or felony warrants
18 for the defendant within the county.

19 (e) Each amnesty program shall accept, in full satisfaction of
20 any eligible fine or bail, 50 percent of the fine or bail amount, as
21 defined in subdivision (c) of this section. Payment of a fine or bail
22 under an amnesty program implemented pursuant to this section
23 shall be accepted beginning January 1, 2012, and ending June 30,
24 2012. The Judicial Council shall adopt guidelines for the amnesty
25 program no later than November 1, 2011, and each program shall
26 be conducted in accordance with Judicial Council guidelines.

27 (f) No criminal action shall be brought against a person for a
28 delinquent fine or bail paid under the amnesty program.

29 (g) The total amount of funds collected under the amnesty
30 program shall as soon as practical after receipt thereof be deposited
31 in the county treasury or the account established under Section
32 77009 of the Government Code. Any unreimbursed costs of
33 operating the amnesty program, excluding capital expenditures,
34 may be deducted from the revenues collected under the amnesty
35 program by the court or the county that incurred the expense of
36 operating the program. Notwithstanding Section 1203.1d of the
37 Penal Code, the remaining revenues collected under the amnesty
38 program shall be distributed on a pro rata basis in the same manner
39 as a partial payment distributed pursuant to Section 1462.5 of the
40 Penal Code.

(h) Each court or county implementing an amnesty program shall file, not later than September 30, 2012, a written report with the Judicial Council, on a form approved by the Judicial Council. The report shall include information about the number of cases resolved, the amount of money collected, and the operating costs of the amnesty program. Notwithstanding Section 10231.5 of the Government Code, on or before December 31, 2012, the Judicial Council shall submit a report to the Legislature summarizing the information provided by each court or county.

SEC. 90. *Section 4474.5 of the Welfare and Institutions Code is amended to read:*

4474.5. (a) In order to meet the unique medical health needs of consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center, and consumers transitioning from Lanterman Developmental Center into various health plans *in central and southern California counties pursuant to the Plan for the Closure of Lanterman Developmental Center*, whose individual program plans document the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal fee-for-service system, services provided under the contract shall be provided by Medi-Cal managed care health plans that are currently operational in these counties—~~as~~. *For consumers transitioning from Agnews Developmental Center, the Medi-Cal managed care health plan shall be a county organized health system or a local initiative if consumers, where applicable, choose to enroll. For consumers transitioning from Lanterman Developmental Center, the Medi-Cal managed care health plan shall be any plan operating in the various counties if consumers choose to enroll or, where applicable, are enrolled by mandate pursuant to Section 14182.* Reimbursement shall be by the State Department of Health Care Services for all Medi-Cal services provided under the contract that are not reimbursed by the Medicare Program.

(b) (1) Medi-Cal managed care health plans enrolling ~~members~~ *consumers transitioning from Agnews Developmental Center as referred to in subdivision (a) shall be further reimbursed for the reasonable cost of administrative services.* ~~Administrative services~~

(2) *Notwithstanding subdivision (c), Medi-Cal managed care health plans enrolling consumers transitioning from Lanterman*

1 *Developmental Center as referred to in subdivision (a) shall be*
2 *paid a full-risk capitation payment.*

3 (3) “Administrative services” pursuant to this subdivision
4 include, but are not limited to, coordination of care and case
5 management not provided by a regional center, provider
6 credentialing and contracting, quality oversight, assuring member
7 access to covered services, consultation with Agnews
8 Developmental Center staff, ~~Lanterman Developmental Center~~
9 ~~staff~~, regional center staff, State Department of Developmental
10 Services staff, contractors, and family members, and financial
11 management of the program, including claims processing.
12 ~~Reasonable cost is defined as~~ “Reasonable cost” means the actual
13 cost incurred by the Medi-Cal managed care health plan, including
14 both direct and indirect costs incurred by the Medi-Cal managed
15 care health plan, in the performance of administrative services,
16 but shall not include any incurred costs found by the State
17 Department of Health Care Services to be unnecessary for the
18 efficient delivery of necessary health services. Payment for
19 administrative services shall continue on a reasonable cost basis
20 until sufficient cost experience exists to allow these costs to be
21 part of an all-inclusive capitation rate covering both administrative
22 services and direct patient care services.

23 (c) Until the State Department of Health Care Services is able
24 to determine by actuarial methods, prospective per capita rates of
25 payment for services for those members who enroll in the Medi-Cal
26 managed care health plans specified in subdivision (a), the State
27 Department of Health Care Services shall reimburse the Medi-Cal
28 managed care health plans for the net reasonable cost of direct
29 patient care services and supplies set forth in the scope of services
30 in the contract between the Medi-Cal managed care health plans
31 and the State Department of Health Care Services and that are not
32 reimbursed by the Medicare Program. ~~Net reasonable cost is~~
33 ~~defined~~ “Net reasonable cost” means the actual cost incurred by
34 the Medi-Cal managed care health plans, as measured by the
35 Medi-Cal managed care health plan’s payments to providers of
36 services and supplies, less payments made to the plans by third
37 parties other than Medicare, and shall not include any incurred
38 cost found to be unnecessary by the State Department of Health
39 Care Services in the efficient delivery of necessary health services.
40 Reimbursement shall be accomplished by the State Department

1 of Health Care Services making estimated payments at reasonable
2 intervals, with these estimates being reconciled to actual net
3 reasonable cost at least semiannually.

4 (d) The State Department of Health Care Services shall seek
5 any approval necessary for implementation of this section from
6 the federal government, for purposes of federal financial
7 participation under Title XIX of the Social Security Act (42 U.S.C.
8 Sec. 1396 et seq.). Notwithstanding any other provision of law,
9 ~~this section subdivisions (a) to (c), inclusive,~~ shall be implemented
10 only to the extent that federal financial participation is available
11 pursuant to necessary federal approvals.

12 *SEC. 91. Section 14007.9 of the Welfare and Institutions Code,*
13 *as amended by Section 1 of Chapter 282 of the Statutes of 2009,*
14 *is amended to read:*

15 14007.9. (a) (1) The department shall adopt the option made
16 available under Section 1902(a)(10)(A)(ii)(XIII) of the federal
17 Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII)). In
18 order to be eligible for benefits under this section, an individual
19 shall be required to meet all of the following requirements:

20 (A) His or her net countable income is less than 250 percent of
21 the federal poverty level for one person or, if the deeming of
22 spousal income applies to the individual, his or her net countable
23 income is less than 250 percent of the federal poverty level for
24 two persons.

25 (B) He or she is disabled under Title II of the federal Social
26 Security Act (42 U.S.C. Sec. 401 et seq.), Title XVI of the federal
27 Social Security Act (42 U.S.C. Sec. 1381 et seq.), or Section
28 1902(v) of the federal Social Security Act (42 U.S.C. Sec.
29 1396a(v)). An individual shall be determined to be eligible under
30 this section without regard to his or her ability to engage in, or
31 actual engagement in, substantial gainful activity, as defined in
32 Section 223(d)(4) of the federal Social Security Act (42 U.S.C.
33 Sec. 423(d)(4)).

34 (C) Except as otherwise provided in this section, his or her net
35 nonexempt resources, which shall be determined in accordance
36 with the methodology used under Title XVI of the federal Social
37 Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the
38 limits provided for under those provisions.

39 (2) To the extent federal financial participation is available, an
40 individual otherwise eligible under this section, but who is

1 temporarily unemployed, may elect to remain on Medi-Cal under
2 this section for up to 26 weeks, provided the individual continues
3 to pay premiums during the temporary period of unemployment.

4 (b) (1) Countable income shall be determined under Section
5 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a),
6 except that the individual's disability income, including all federal
7 and state disability benefits and private disability insurance, shall
8 be exempted. Resources excluded under Section 1613 of the federal
9 Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

10 (2) Resources in the form of employer or individual retirement
11 arrangements authorized under the Internal Revenue Code shall
12 be exempted as authorized by Section 1902(r) of the federal Social
13 Security Act (42 U.S.C. Sec. 1396a(r)).

14 (3) (A) For the purposes of calculating countable income under
15 this section, an income exemption shall be applied as necessary
16 to adjust the income standard so that it is the same as the income
17 standard that was in place on May 1, 2009.

18 (B) This additional income exemption shall cease to be
19 implemented when the SSI/SSP program payment levels increase
20 beyond those in effect on May 1, 2009.

21 (C) Notwithstanding Chapter 3.5 (commencing with Section
22 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
23 the department shall implement this paragraph by means of an
24 all-county letter or similar instruction without taking regulatory
25 action.

26 (4) Retained earned income of an eligible individual who is
27 receiving health care benefits under this section shall be considered
28 an exempt resource when held in a separately identifiable account
29 and not commingled with other resources, as authorized by Section
30 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec.
31 1396a(r)(2)).

32 (5) Social security disability income that converts to social
33 security retirement income upon the retirement of an individual,
34 including any increases in the amount of that income, shall be
35 exempt. The department shall submit a state plan amendment for
36 this specific exemption, and the exemption shall be implemented
37 only if, and to the extent that, the state plan amendment is
38 approved.

39 (c) All resources exempted pursuant to paragraph (2) of
40 subdivision (b) for an individual who is receiving health care

benefits under this section shall continue to be exempt under any other Medi-Cal program that is subject to Section 1902(r)(2) of the federal Social Security Act (42 U.S.C. Sec. 1396a(r)(2)) under which the beneficiary later becomes eligible for medical assistance where that eligibility is based on age, blindness, or disability. The department shall submit a state plan amendment for this specific exemption, and the exemption shall be implemented only if, and to the extent that, the state plan amendment is approved.

(d) After an individual is determined eligible for Medi-Cal benefits under this section, the individual's countable income, as determined under Section 1612 of the federal Social Security Act (42 U.S.C. Sec. 1382a), shall be used to determine the amount of the individual's required premium payment, as described in subdivision (f). Disability income and converted retirement income made exempt under paragraphs (1) and (5), respectively, of subdivision (b) for eligibility purposes shall be considered countable income for purposes of determining the amount of the required premium payment.

(e) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(f) (1) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision. Each individual shall pay a monthly premium that is equal to 5 percent of his or her individual countable income, as described in subdivision (d), or if the deeming of spousal income of an ineligible spouse applies, a monthly premium that is equal to 5 percent of the total countable income of both spouses, except that the minimum premium payment per eligible individual shall be twenty dollars (\$20) per month, and the maximum premium payment per eligible individual shall be two hundred fifty dollars (\$250) per month.

(2) The amendments made to this subdivision by ~~the act that added subdivision (k)~~ *Chapter 282 of the Statutes of 2009* shall be implemented no later than 90 days after the operative date specified in ~~that subdivision~~ *paragraph (2) of subdivision (k)*.

(g) In order to implement the collection of premiums under this section, the department may develop and execute a contract with

1 a public or private entity to collect premiums, or may amend any
2 existing or future premium-collection contract that it has executed.
3 Notwithstanding any other provision of law, any contract developed
4 and executed or amended pursuant to this subdivision is exempt
5 from the approval of the Director of General Services and from
6 the Public Contract Code.

7 (h) Notwithstanding the rulemaking provisions of Chapter 3.5
8 (commencing with Section 11340) of Part 1 of Division 3 of Title
9 2 of the Government Code, the department shall implement,
10 without taking any regulatory action, this section by means of an
11 all-county letter or similar instruction. Thereafter, the department
12 shall adopt regulations in accordance with the requirements of
13 Chapter 3.5 (commencing with Section 11340) of Part 1 of Division
14 3 of Title 2 of the Government Code.

15 (i) Notwithstanding any other law, this section shall be
16 implemented only if, and to the extent that, the department
17 determines that federal financial participation is available pursuant
18 to Title XIX of the federal Social Security Act (42 U.S.C. Sec.
19 1396 et seq.) and only to the extent that the department seeks and
20 obtains approval of all necessary Medicaid state plan amendments.

21 (j) If any provision of this section, or its application, is held
22 invalid by a final judicial determination, it shall cease to be
23 implemented. A determination of invalidity shall not affect other
24 provisions or applications of this section that can be given effect
25 without the implementation of the invalid provision or application.

26 (k) ~~The—(1) Except as provided in paragraph (2), the~~
27 ~~amendments made to this section by the act that added this~~
28 ~~subdivision Chapter 282 of the Statutes of 2009 shall not become~~
29 ~~operative until 30 days after the date that the increase in the state's~~
30 ~~federal medical assistance percentage (FMAP) pursuant to the~~
31 ~~federal American Recovery and Reinvestment Act of 2009 (P.L.~~
32 ~~(Public Law 111-5) is no longer available under that act or any~~
33 ~~extension of that act.~~

34 (2) *The amendments made to this section by Chapter 282 of the*
35 *Statutes of 2009 contained in subdivisions (d) and (f) shall not*
36 *become operative until 30 days after the date that the director*
37 *executes a declaration stating that the implementation of*
38 *subdivisions (d) and (f) will not jeopardize the state's ability to*
39 *receive federal financial participation under the federal Patient*
40 *Protection and Affordable Care Act (Public Law 111-148) or any*

1 *amendment or extension of that act, any increase in the FMAP*
2 *available on or after October 1, 2008, or any additional federal*
3 *funds that the director, in consultation with the Department of*
4 *Finance, determines would be advantageous to the state.*

5 *(3) If at any time the director determines that the statement in*
6 *the declaration executed pursuant to paragraph (2) may no longer*
7 *be accurate, the director shall give notice to the Joint Legislative*
8 *Budget Committee and to the Department of Finance. After giving*
9 *notice, the amendments made to this section by Chapter 282 of the*
10 *Statutes of 2009 contained in subdivisions (d) and (f) shall become*
11 *inoperative on the date that the director executes a declaration*
12 *stating that the department has determined, in consultation with*
13 *the Department of Finance, that it is necessary to cease to*
14 *implement subdivisions (d) and (f) in order to receive federal*
15 *financial participation, any increase in the FMAP available on or*
16 *after October 1, 2008, or any additional federal funds that the*
17 *director, in consultation with the Department of Finance, has*
18 *determined would be advantageous to the state, in which case,*
19 *subdivision (d) of this section, as stated by Section 32 of Chapter*
20 *5 of the Fourth Extraordinary Session of the Statutes of 2009, shall*
21 *be operative.*

22 *(4) The director shall post a declaration made pursuant to*
23 *paragraph (2) or (3) on the department's Internet Web site and*
24 *the director shall send the declaration to the Secretary of State,*
25 *the Secretary of the Senate, the Chief Clerk of the Assembly, and*
26 *the Legislative Counsel.*

27 *(l) Notwithstanding Chapter 3.5 (commencing with Section*
28 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
29 *the department may implement subdivision (k) by means of*
30 *all-county letters or similar instruction, without taking regulatory*
31 *action.*

32 *SEC. 92. Section 14091.3 of the Welfare and Institutions Code*
33 *is amended to read:*

34 *14091.3. (a) For purposes of this section, the following*
35 *definitions shall apply:*

36 *(1) "Medi-Cal managed care plan contracts" means those*
37 *contracts entered into with the department by any individual,*
38 *organization, or entity pursuant to Article 2.7 (commencing with*
39 *Section 14087.3), Article 2.8 (commencing with Section 14087.5),*
40 *Article 2.91 (commencing with Section 14089) of this chapter, or*

Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8, or Chapter 8.75 (commencing with Section 14590).

(2) “Medi-Cal managed care health plan” means an individual, organization, or entity operating under a Medi-Cal managed care plan contract with the department under this chapter, Chapter 8 (commencing with Section 14200), or Chapter 8.75 (commencing with Section 14590).

(b) The department shall take all appropriate steps to amend the Medicaid State Plan, if necessary, to carry out this section. This section shall be implemented only to the extent that federal financial participation is available. The department shall adopt rules and regulations to carry out this section. Until January 1, 2010, any rules and regulations adopted pursuant to this subdivision may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. The regulations shall become effective immediately upon filing with the Secretary of State.

(c) Any hospital that does not have in effect a contract with a Medi-Cal managed care health plan, as defined in paragraph (2) of subdivision (a), that establishes payment amounts for services furnished to a beneficiary enrolled in that plan shall accept as payment in full, from all these plans, the following amounts:

(1) For outpatient services, the Medi-Cal fee-for-service (FFS) payment amounts.

(2) For emergency inpatient services, the average per diem contract rate specified in paragraph (2) of subdivision (b) of Section 14166.245, except that the payment amount shall not be reduced by 5 percent. For the purposes of this paragraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program described in Article 2.6 (commencing with Section 14081), and small and rural hospitals specified in Section 124840 of the Health and Safety Code.

(3) For poststabilization services following an emergency admission, payment amounts shall be consistent with subdivision

(e) of Section 438.114 of Title 42 of the Code of Federal Regulations. This paragraph shall only be implemented to the extent that contract amendment language providing for these payments is approved by CMS. For purposes of this paragraph, this payment amount shall apply to all hospitals, including hospitals that contract with the department under the Medi-Cal Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081).

(d) Medi-Cal managed care health plans that, pursuant to the department's encouragement in All Plan Letter 07003, have been paying out-of-network hospitals the most recent California Medical Assistance Commission regional average per diem rate as a temporary rate for purposes of Section 1932(b)(2)(D) of the Social Security Act (SSA), which became effective January 1, 2007, shall make reconciliations and adjustments for all hospital payments made since January 1, 2007, based upon rates published by the department pursuant to Section 1932(b)(2)(D) of the SSA and effective January 1, 2007, to June 30, 2008, inclusive, and, if applicable, provide supplemental payments to hospitals as necessary to make payments that conform with Section 1932(b)(2)(D) of the SSA. In order to provide managed care health plans with 60 working days to make any necessary supplemental payments to hospitals prior to these payments becoming subject to the payment of interest, Section 1300.71 of Title 28 of the California Code of Regulations shall not apply to these supplemental payments until 30 working days following the publication by the department of the rates.

(e) (1) The department shall provide a written report to the policy and fiscal committees of the Legislature on October 1, 2009, and May 1, 2010, on the implementation and impact made by this section, including the impact of these changes on access to hospitals by managed care enrollees and on contracting between hospitals and managed care health plans, including the increase or decrease in the number of these contracts.

(2) Not later than August 1, 2010, the department shall report to the Legislature on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing managed care enrollee access to hospital services, the impact of this section on managed care health plan capitation rates, the impact of this section on the extent of contracting between

1 managed care health plans and hospitals, and fiscal impact on the
2 state.

3 (3) For the purposes of preparing the annual status reports and
4 the final evaluation report required pursuant to this subdivision,
5 Medi-Cal managed care health plans shall provide the department
6 with all data and documentation, including contracts with providers,
7 including hospitals, as deemed necessary by the department to
8 evaluate the impact of the implementation of this section. In order
9 to ensure the confidentiality of managed care health plan
10 proprietary information, and thereby enable the department to have
11 access to all of the data necessary to provide the Legislature with
12 accurate and meaningful information regarding the impact of this
13 section, all information and documentation provided to the
14 department pursuant to this section shall be considered proprietary
15 and shall be exempt from disclosure as official information
16 pursuant to subdivision (k) of Section 6254 of the Government
17 Code as contained in the California Public Records Act (Division
18 7 (commencing with Section 6250) of Title 1 of the Government
19 Code).

20 (f) This section shall remain in effect only until January 1, ~~2012~~
21 2013, and as of that date is repealed, unless a later enacted statute,
22 that is enacted before January 1, ~~2012~~ 2013, deletes or extends
23 that date.

24 SEC. 93. Section 14105.07 is added to the Welfare and
25 Institutions Code, to read:

26 14105.07. (a) The Legislature finds and declares all of the
27 following:

28 (1) Costs within the Medi-Cal program continue to grow due
29 to the rising cost of providing health care throughout the state and
30 also due to increases in enrollment, which are more pronounced
31 during difficult economic times.

32 (2) In order to minimize the need for drastically cutting
33 enrollment standards or benefits during times of economic crisis,
34 it is crucial to find areas within the program where reimbursement
35 levels are higher than required under the standard provided in
36 Section 1902(a)(30)(A) of the federal Social Security Act and can
37 be reduced in accordance with federal law.

38 (3) The Medi-Cal program delivers its services and benefits to
39 Medi-Cal beneficiaries through a wide variety of health care
40 providers, some of which deliver care via managed care or other

1 contract models while others do so through fee-for-service
2 arrangements.

3 (4) The setting of rates within the Medi-Cal program is complex
4 and is subject to close supervision by the United States Department
5 of Health and Human Services.

6 (5) As the single state agency for Medicaid in California, the
7 State Department of Health Care Services has unique expertise
8 that can inform decisions that set or adjust reimbursement
9 methodologies and levels consistent with the requirements of
10 federal law.

11 (b) Therefore, it is the intent of the Legislature for the
12 department to analyze and identify where reimbursement levels
13 can be reduced consistent with the standard provided in Section
14 1902(a)(30)(A) of the federal Social Security Act and also
15 consistent with federal and state law and policies, including any
16 exemptions contained in the act that added this section, provided
17 that the reductions in reimbursement shall not exceed 10 percent
18 on an aggregate basis for all providers, services, and products.

19 (c) (1) Notwithstanding any other provision of law and except
20 as provided in paragraphs (2), (3), and (4), for dates of service
21 on and after June 1, 2011, payments to intermediate care facilities
22 for the developmentally disabled, licensed pursuant to subdivision
23 (e), (g), or (h) of Section 1250 of the Health and Safety Code, and
24 facilities providing continuous skilled nursing care to
25 developmentally disabled individuals pursuant to the pilot project
26 established by Section 14132.20, as determined by the applicable
27 methodology for setting reimbursement rates for these facilities,
28 shall not exceed the reimbursement rates that were applicable to
29 those providers in the 2008–09 rate year, reduced by 10 percent.

30 (2) Notwithstanding any other provision of law, the director
31 may adjust the percentage reductions specified in paragraph (1),
32 as long as the resulting reductions, in the aggregate, total no more
33 than 10 percent.

34 (3) The adjustments authorized under this subdivision shall be
35 implemented only if the director determines that the payments
36 resulting from the adjustments comply with subdivision (d).

37 (4) Payments to facilities owned or operated by the state shall
38 be exempt from the payment reduction as required in paragraph
39 (1).

1 (d) (1) Notwithstanding any other provision of this section, the
2 payment reductions and adjustments required by subdivision (c)
3 shall be implemented only if the director determines that the
4 payments that result from the application of subdivision (c) will
5 comply with applicable federal Medicaid requirements and that
6 federal financial participation will be available.

7 (2) In determining whether federal financial participation is
8 available, the director shall determine whether the payments
9 comply with applicable federal Medicaid requirements, including
10 those set forth in Section 1396a(a)(30)(A) of Title 42 of the United
11 States Code.

12 (3) To the extent that the director determines that the payments
13 do not comply with applicable federal Medicaid requirements or
14 that federal financial participation is not available with respect
15 to any payment that is reduced pursuant to this section, the director
16 retains the discretion to not implement the particular payment
17 reduction or adjustment and may adjust the payment as necessary
18 to comply with federal Medicaid requirements.

19 (4) The director shall seek any necessary federal approvals for
20 the implementation of this section. This section shall not be
21 implemented until federal approval is obtained. When federal
22 approval is obtained, the payments resulting from the application
23 of subdivision (c) shall be implemented retroactively to June 1,
24 2011, or on any other date or dates as may be applicable.

25 (e) For managed care health plans that contract with the
26 department pursuant to this chapter and Chapter 8 (commencing
27 with Section 14200), except for contracts with the Senior Care
28 Action Network and AIDS Healthcare Foundation, and to the
29 extent that these services are provided through any of those
30 contracts, payments shall be reduced by the actuarial equivalent
31 amount of the reduced provider reimbursements specified in
32 subdivision (c) pursuant to contract amendments or change orders
33 effective on July 1, 2011, or thereafter.

34 SEC. 93.2. Section 14105.191 of the Welfare and Institutions
35 Code is amended to read:

36 14105.191. (a) Notwithstanding any other provision of law,
37 in order to implement changes in the level of funding for health
38 care services, the director shall reduce provider payments, as
39 specified in this section.

1 (b) (1) Except as otherwise provided in this section, payments
2 shall be reduced by 1 percent for Medi-Cal fee-for-service benefits
3 for dates of service on and after March 1, 2009.

4 (2) Except as provided in subdivision (d), for dates of service
5 on and after March 1, 2009, payments to the following classes of
6 providers shall be reduced by 5 percent for Medi-Cal
7 fee-for-service benefits:

8 (A) Intermediate care facilities, excluding those facilities
9 identified in paragraph (5) of subdivision (d). For purposes of this
10 section, “intermediate care facility” has the same meaning as
11 defined in Section 51118 of Title 22 of the California Code of
12 Regulations.

13 (B) Skilled nursing facilities that are distinct parts of general
14 acute care hospitals. For purposes of this section, “distinct part”
15 has the same meaning as defined in Section 72041 of Title 22 of
16 the California Code of Regulations.

17 (C) Rural swing-bed facilities.

18 (D) Subacute care units that are, or are parts of, distinct parts
19 of general acute care hospitals. For purposes of this subparagraph,
20 “subacute care unit” has the same meaning as defined in Section
21 51215.5 of Title 22 of the California Code of Regulations.

22 (E) Pediatric subacute care units that are, or are parts of, distinct
23 parts of general acute care hospitals. For purposes of this
24 subparagraph, “pediatric subacute care unit” has the same meaning
25 as defined in Section 51215.8 of Title 22 of the California Code
26 of Regulations.

27 (F) Adult day health care centers.

28 (3) Except as provided in subdivision (d), for dates of service
29 on and after March 1, 2009, Medi-Cal fee-for-service payments
30 to pharmacies shall be reduced by 5 percent.

31 (4) Except as provided in subdivision (d), payments shall be
32 reduced by 1 percent for non-Medi-Cal programs described in
33 Article 6 (commencing with Section 124025) of Chapter 3 of Part
34 2 of Division 106 of the Health and Safety Code, and Section
35 14105.18, for dates of service on and after March 1, 2009.

36 (5) For managed health care plans that contract with the
37 department pursuant to this chapter, Chapter 8 (commencing with
38 Section 14200), and Chapter 8.75 (commencing with Section
39 14590), payments shall be reduced by the actuarial equivalent
40 amount of the payment reductions specified in this subdivision

1 pursuant to contract amendments or change orders effective on
2 July 1, 2008, or thereafter.

3 (c) Notwithstanding any other provision of this section,
4 payments to hospitals that are not under contract with the State
5 Department of Health Care Services pursuant to Article 2.6
6 (commencing with Section 14081) for inpatient hospital services
7 provided to Medi-Cal beneficiaries and that are subject to Section
8 14166.245 shall be governed by that section.

9 (d) To the extent applicable, the services, facilities, and
10 payments listed in this subdivision shall be exempt from the
11 payment reductions specified in subdivision (b):

12 (1) Acute hospital inpatient services that are paid under contracts
13 pursuant to Article 2.6 (commencing with Section 14081).

14 (2) Federally qualified health center services, including those
15 facilities deemed to have federally qualified health center status
16 pursuant to a waiver pursuant to subsection (a) of Section 1115 of
17 the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

18 (3) Rural health clinic services.

19 (4) Skilled nursing facilities licensed pursuant to subdivision
20 (c) of Section 1250 of the Health and Safety Code other than those
21 specified in paragraph (2) of subdivision (b).

22 (5) Intermediate care facilities for the developmentally disabled
23 licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of
24 the Health and Safety Code, or facilities providing continuous
25 skilled nursing care to developmentally disabled individuals
26 pursuant to the pilot project established by Section 14495.10.

27 (6) Payments to facilities owned or operated by the State
28 Department of Mental Health or the State Department of
29 Developmental Services.

30 (7) Hospice services.

31 (8) Contract services, as designated by the director pursuant to
32 subdivision (g).

33 (9) Payments to providers to the extent that the payments are
34 funded by means of a certified public expenditure or an
35 intergovernmental transfer pursuant to Section 433.51 of Title 42
36 of the Code of Federal Regulations.

37 (10) Services pursuant to local assistance contracts and
38 interagency agreements to the extent the funding is not included
39 in the funds appropriated to the department in the annual Budget
40 Act.

1 (11) Payments to Medi-Cal managed care plans pursuant to
2 Section 4474.5 for services to consumers transitioning from
3 Agnews Developmental Center into the Counties of Alameda, San
4 Mateo, and Santa Clara pursuant to the Plan for the Closure of
5 Agnews Developmental Center.

6 (12) Breast and cervical cancer treatment provided pursuant to
7 Section 14007.71 and as described in paragraph (3) of subdivision
8 (a) of Section 14105.18 or Article 1.5 (commencing with Section
9 104160) of Chapter 2 of Part 1 of Division 103 of the Health and
10 Safety Code.

11 (13) The Family Planning, Access, Care, and Treatment (Family
12 PACT) Waiver Program pursuant to ~~Section 14105.18~~ *subdivision*
13 *(aa) of Section 14132*.

14 (14) Small and rural hospitals, as defined in Section 124840 of
15 the Health and Safety Code.

16 (e) Subject to the exemptions listed in subdivision (d), the
17 payment reductions required by paragraph (1) of subdivision (b)
18 shall apply to the benefits rendered by any provider who may be
19 authorized to bill for provision of the benefit, including, but not
20 limited to, physicians, podiatrists, nurse practitioners, certified
21 nurse midwives, nurse anesthetists, and organized outpatient
22 clinics.

23 (f) (1) Notwithstanding any other provision of law, Medi-Cal
24 reimbursement rates applicable to the classes of providers identified
25 in paragraph (2) of subdivision (b), for services rendered during
26 the 2009–10 rate year and each rate year thereafter, shall not exceed
27 the reimbursement rates that were applicable to those classes of
28 providers in the 2008–09 rate year.

29 (2) In addition to the classes of providers described in paragraph
30 (1), Medi-Cal reimbursement rates applicable to the following
31 classes of facilities for services rendered during the 2009–10 rate
32 year, and each rate year thereafter, shall not exceed the
33 reimbursement rates that were applicable to those facilities and
34 services in the 2008–09 rate year:

35 (A) Facilities identified in paragraph (5) of subdivision (d).

36 (B) Freestanding pediatric subacute care units, as defined in
37 Section 51215.8 of Title 22 of the California Code of Regulations.

38 (3) Paragraphs (1) and (2) shall not apply to providers that are
39 paid pursuant to Article 3.8 (commencing with Section 14126), or
40 to services, facilities, and payments specified in subdivision (d),

1 with the exception of facilities described in paragraph (5) of
2 subdivision (d).

3 (4) The limitation set forth in this subdivision shall be applied
4 only after the reductions in paragraph (2) of subdivision (b) have
5 been made.

6 (g) Notwithstanding Chapter 3.5 (commencing with Section
7 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
8 the department may implement and administer this section by
9 means of provider bulletins, or similar instructions, without taking
10 regulatory action.

11 (h) The reductions and limitations described in this section shall
12 apply only to payments for benefits when the General Fund share
13 of the payment is paid with funds directly appropriated to the
14 department in the annual Budget Act, and shall not apply to
15 payments for benefits paid with funds appropriated to other
16 departments or agencies.

17 (i) The department shall promptly seek any necessary federal
18 approvals for the implementation of this section. To the extent that
19 federal financial participation is not available with respect to any
20 payment that is reduced or limited pursuant to this section, the
21 director may elect not to implement that reduction or limitation.

22 (j) *This section shall become inoperative for dates of service*
23 *on and after June 1, 2011, and shall, on July 1, 2014, be repealed.*

24 SEC. 93.5. Section 14105.192 is added to the Welfare and
25 Institutions Code, to read:

26 14105.192. (a) *The Legislature finds and declares the*
27 *following:*

28 (1) *Costs within the Medi-Cal program continue to grow due*
29 *to the rising cost of providing health care throughout the state and*
30 *also due to increases in enrollment, which are more pronounced*
31 *during difficult economic times.*

32 (2) *In order to minimize the need for drastically cutting*
33 *enrollment standards or benefits during times of economic crisis,*
34 *it is crucial to find areas within the program where reimbursement*
35 *levels are higher than required under the standard provided in*
36 *Section 1902(a)(30)(A) of the federal Social Security Act and can*
37 *be reduced in accordance with federal law.*

38 (3) *The Medi-Cal program delivers its services and benefits to*
39 *Medi-Cal beneficiaries through a wide variety of health care*
40 *providers, some of which deliver care via managed care or other*

1 contract models while others do so through fee-for-service
2 arrangements.

3 (4) The setting of rates within the Medi-Cal program is complex
4 and is subject to close supervision by the United States Department
5 of Health and Human Services.

6 (5) As the single state agency for Medicaid in California, the
7 department has unique expertise that can inform decisions that
8 set or adjust reimbursement methodologies and levels consistent
9 with the requirements of federal law.

10 (b) Therefore, it is the intent of the Legislature for the
11 department to analyze and identify where reimbursement levels
12 can be reduced consistent with the standard provided in Section
13 1902(a)(30)(A) of the federal Social Security Act and consistent
14 with federal and state law and policies, including any exemptions
15 contained in the provisions of the act that added this section,
16 provided that the reductions in reimbursement shall not exceed
17 10 percent on an aggregate basis for all providers, services and
18 products.

19 (c) Notwithstanding any other provision of law, the director
20 shall adjust provider payments, as specified in this section.

21 (d) (1) Except as otherwise provided in this section, payments
22 shall be reduced by 10 percent for Medi-Cal fee-for-service benefits
23 for dates of service on and after June 1, 2011.

24 (2) For managed health care plans that contract with the
25 department pursuant to this chapter or Chapter 8 (commencing
26 with Section 14200), except contracts with Senior Care Action
27 Network and AIDS Healthcare Foundation, payments shall be
28 reduced by the actuarial equivalent amount of the payment
29 reductions specified in this section pursuant to contract
30 amendments or change orders effective on July 1, 2011, or
31 thereafter.

32 (3) Payments shall be reduced by 10 percent for non-Medi-Cal
33 programs described in Article 6 (commencing with Section 124025)
34 of Chapter 3 of Part 2 of Division 106 of the Health and Safety
35 Code, and Section 14105.18, for dates of service on and after June
36 1, 2011. This paragraph shall not apply to inpatient hospital
37 services provided in a hospital that is paid under contract pursuant
38 to Article 2.6 (commencing with Section 14081).

39 (4) (A) Notwithstanding any other provision of law, the director
40 may adjust the payments specified in paragraphs (1) and (3) of

1 *this subdivision with respect to one or more categories of Medi-Cal*
2 *providers, or for one or more products or services rendered, or*
3 *any combination thereof, so long as the resulting reductions to*
4 *any category of Medi-Cal providers, in the aggregate, total no*
5 *more than 10 percent.*

6 *(B) The adjustments authorized in subparagraph (A) shall be*
7 *implemented only if the director determines that, for each affected*
8 *product, service or provider category, the payments resulting from*
9 *the adjustment comply with subdivision (m).*

10 *(e) Notwithstanding any other provision of this section, payments*
11 *to hospitals that are not under contract with the State Department*
12 *of Health Care Services pursuant to Article 2.6 (commencing with*
13 *Section 14081) for inpatient hospital services provided to Medi-Cal*
14 *beneficiaries and that are subject to Section 14166.245 shall be*
15 *governed by that section.*

16 *(f) Notwithstanding any other provision of this section, the*
17 *following shall apply:*

18 *(1) Payments to providers that are paid pursuant to Article 3.8*
19 *(commencing with Section 14126) shall be governed by that article.*

20 *(2) (A) Subject to subparagraph (B), for dates of service on*
21 *and after June 1, 2011, Medi-Cal reimbursement rates for*
22 *intermediate care facilities for the developmentally disabled*
23 *licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of*
24 *the Health and Safety Code, and facilities providing continuous*
25 *skilled nursing care to developmentally disabled individuals*
26 *pursuant to the pilot project established by Section 14132.20, as*
27 *determined by the applicable methodology for setting*
28 *reimbursement rates for these facilities, shall not exceed the*
29 *reimbursement rates that were applicable to providers in the*
30 *2008-09 rate year.*

31 *(B) (i) If Section 14105.07 is added to the Welfare and*
32 *Institutions Code during the 2011-12 Regular Session of the*
33 *Legislature, subparagraph (A) shall become inoperative.*

34 *(ii) If Section 14105.07 is added to the Welfare and Institutions*
35 *Code during the 2011-12 Regular Session of the Legislature, then*
36 *for dates of service on and after June 1, 2011, payments to*
37 *intermediate care facilities for the developmentally disabled*
38 *licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of*
39 *the Health and Safety Code, and facilities providing continuous*
40 *skilled nursing care to developmentally disabled individuals*

1 *pursuant to the pilot project established by Section 14132.20, shall*
2 *be governed by the applicable methodology for setting*
3 *reimbursement rates for these facilities and by Section 14105.07.*

4 *(g) The department may enter into contracts with a vendor for*
5 *the purposes of implementing this section on a bid or nonbid basis.*
6 *In order to achieve maximum cost savings, the Legislature declares*
7 *that an expedited process for contracts under this subdivision is*
8 *necessary. Therefore, contracts entered into to implement this*
9 *section and all contract amendments and change orders shall be*
10 *exempt from Chapter 2 (commencing with Section 10290) of Part*
11 *2 Division 2 of the Public Contract Code.*

12 *(h) To the extent applicable, the services, facilities, and*
13 *payments listed in this subdivision shall be exempt from the*
14 *payment reductions specified in subdivision (d) as follows:*

15 *(1) Acute hospital inpatient services that are paid under*
16 *contracts pursuant to Article 2.6 (commencing with Section 14081).*

17 *(2) Federally qualified health center services, including those*
18 *facilities deemed to have federally qualified health center status*
19 *pursuant to a waiver pursuant to subsection (a) of Section 1115*
20 *of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).*

21 *(3) Rural health clinic services.*

22 *(4) Payments to facilities owned or operated by the State*
23 *Department of Mental Health or the State Department of*
24 *Developmental Services.*

25 *(5) Hospice services.*

26 *(6) Contract services, as designated by the director pursuant*
27 *to subdivision (k).*

28 *(7) Payments to providers to the extent that the payments are*
29 *funded by means of a certified public expenditure or an*
30 *intergovernmental transfer pursuant to Section 433.51 of Title 42*
31 *of the Code of Federal Regulations. This paragraph shall apply*
32 *to payments described in paragraph (3) of subdivision (d) only to*
33 *the extent that they are also exempt from reduction pursuant to*
34 *subdivision (l).*

35 *(8) Services pursuant to local assistance contracts and*
36 *interagency agreements to the extent the funding is not included*
37 *in the funds appropriated to the department in the annual Budget*
38 *Act.*

39 *(9) Breast and cervical cancer treatment provided pursuant to*
40 *Section 14007.71 and as described in paragraph (3) of subdivision*

1 (a) of Section 14105.18 or Article 1.5 (commencing with Section
2 104160) of Chapter 2 of Part 1 of Division 103 of the Health and
3 Safety Code.

4 (10) The Family Planning, Access, Care, and Treatment (Family
5 PACT) Program pursuant to subdivision (aa) of Section 14132.

6 (i) Subject to the exception for services listed in subdivision (h),
7 the payment reductions required by subdivision (d) shall apply to
8 the benefits rendered by any provider who may be authorized to
9 bill for the service, including, but not limited to, physicians,
10 podiatrists, nurse practitioners, certified nurse-midwives, nurse
11 anesthetists, and organized outpatient clinics.

12 (j) Notwithstanding any other provision of law, for dates of
13 service on and after June 1, 2011, Medi-Cal reimbursement rates
14 applicable to the following classes of providers shall not exceed
15 the reimbursement rates that were applicable to those classes of
16 providers in the 2008-09 rate year, as described in subdivision (f)
17 of Section 14105.91, reduced by 10 percent:

18 (1) Intermediate care facilities, excluding those facilities
19 identified in paragraph (2) of subdivision (f). For purposes of this
20 section, "intermediate care facility" has the same meaning as
21 defined in Section 51118 of Title 22 of the California Code of
22 Regulations.

23 (2) Skilled nursing facilities that are distinct parts of general
24 acute care hospitals. For purposes of this section, "distinct part"
25 has the same meaning as defined in Section 72041 of Title 22 of
26 the California Code of Regulations.

27 (3) Rural swing-bed facilities.

28 (4) Subacute care units that are, or are parts of, distinct parts
29 of general acute care hospitals. For purposes of this subparagraph,
30 "subacute care unit" has the same meaning as defined in Section
31 51215.5 of Title 22 of the California Code of Regulations.

32 (5) Pediatric subacute care units that are, or are parts of,
33 distinct parts of general acute care hospitals. For purposes of this
34 subparagraph, "pediatric subacute care unit" has the same
35 meaning as defined in Section 51215.8 of Title 22 of the California
36 Code of Regulations.

37 (6) Adult day health care centers.

38 (7) Freestanding pediatric subacute care units, as defined in
39 Section 51215.8 of Title 22 of the California Code of Regulations.

1 (k) Notwithstanding Chapter 3.5 (commencing with Section
2 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
3 the department may implement and administer this section by
4 means of provider bulletins, or similar instructions, without taking
5 regulatory action.

6 (l) The reductions described in this section shall apply only to
7 payments for services when the General Fund share of the payment
8 is paid with funds directly appropriated to the department in the
9 annual Budget Act and shall not apply to payments for services
10 paid with funds appropriated to other departments or agencies.

11 (m) Notwithstanding any other provision of this section, the
12 payment reductions and adjustments provided for in subdivision
13 (d) shall be implemented only if the director determines that the
14 payments that result from the application of this section will comply
15 with applicable federal Medicaid requirements and that federal
16 financial participation will be available.

17 (1) In determining whether federal financial participation is
18 available, the director shall determine whether the payments
19 comply with applicable federal Medicaid requirements, including
20 those set forth in Section 1396a(a)(30)(A) of Title 42 of the United
21 States Code.

22 (2) To the extent that the director determines that the payments
23 do not comply with the federal Medicaid requirements or that
24 federal financial participation is not available with respect to any
25 payment that is reduced pursuant to this section, the director
26 retains the discretion to not implement the particular payment
27 reduction or adjustment and may adjust the payment as necessary
28 to comply with federal Medicaid requirements.

29 (n) The department shall seek any necessary federal approvals
30 for the implementation of this section.

31 (o) This section shall not be implemented until federal approval
32 is obtained. When federal approval is obtained, the payments
33 resulting from the application of subdivision (d) shall be
34 implemented retroactively to June 1, 2011, or on such other date
35 or dates as may be applicable.

36 SEC. 94. Section 14105.31 of the Welfare and Institutions Code
37 is amended to read:

38 14105.31. For purposes of the Medi-Cal contract drug list, the
39 following definitions shall apply:

1 (a) “Single-source drug” means a drug that is produced and
2 distributed under an original New Drug Application approved by
3 the federal Food and Drug Administration. This shall include a
4 drug marketed by the innovator manufacturer and any
5 cross-licensed producers or distributors operating under the New
6 Drug Application, and shall also include a biological product,
7 except for vaccines, marketed by the innovator manufacturer and
8 any cross-licensed producers or distributors licensed by the federal
9 Food and Drug Administration pursuant to Section 262 of Title
10 42 of the United States Code. A drug ceases to be a single-source
11 drug when the same drug in the same dosage form and strength
12 manufactured by another manufacturer is approved by the federal
13 Food and Drug Administration under the provisions for an
14 Abbreviated New Drug Application.

15 (b) “Best price” means the negotiated price, or the
16 manufacturer’s lowest price available to any class of trade
17 organization or entity, including, but not limited to, wholesalers,
18 retailers, hospitals, repackagers, providers, or governmental entities
19 within the United States, that contracts with a manufacturer for a
20 specified price for drugs, inclusive of cash discounts, free goods,
21 volume discounts, rebates, and on- or off-invoice discounts or
22 credits, shall be based upon the manufacturer’s commonly used
23 retail package sizes for the drug sold by wholesalers to retail
24 pharmacies.

25 ~~(c) “Equalization payment amount” means the amount~~
26 ~~negotiated between the manufacturer and the department for~~
27 ~~reimbursement by the manufacturer, as specified in the contract.~~
28 ~~The equalization payment amount shall be based on the difference~~
29 ~~between the manufacturer’s direct catalog price charged to~~
30 ~~wholesalers and the manufacturer’s best price, as defined in~~
31 ~~subdivision (b).~~

32 ~~(d)~~

33 (c) “Manufacturer” means any person, partnership, corporation,
34 or other institution or entity that is engaged in the production,
35 preparation, propagation, compounding, conversion, or processing
36 of drugs, either directly or indirectly by extraction from substances
37 of natural origin, or independently by means of chemical synthesis,
38 or by a combination of extraction and chemical synthesis, or in
39 the packaging, repackaging, labeling, relabeling, and distribution
40 of drugs.

1 ~~(e)~~

2 (d) “Price escalator” means a mutually agreed upon price
3 specified in the contract, to cover anticipated cost increases over
4 the life of the contract.

5 ~~(f)~~

6 (e) “Medi-Cal pharmacy costs” or “Medi-Cal drug costs” means
7 all reimbursements to pharmacy providers for services or
8 merchandise, including single-source or multiple-source
9 prescription drugs, over-the-counter medications, and medical
10 supplies, or any other costs billed by pharmacy providers under
11 the Medi-Cal program.

12 ~~(g)~~

13 (f) “Medicaid rebate” means the rebate payment made by drug
14 manufacturers pursuant to Section 1927 of the federal Social
15 Security Act (42 U.S.C. Sec. 1396r-8).

16 ~~(h) “State rebate” means any negotiated rebate under the Drug
17 Discount Program in addition to the Medicaid rebate.~~

18 (g) “State rebate” means the amount negotiated between the
19 manufacturer and the department for reimbursement by the
20 manufacturer, as specified in the contract, in addition to the
21 Medicaid rebate.

22 ~~(i)~~

23 (h) “Date of mailing” means the date that is evidenced by the
24 postmark date by the United States Postal Service or other common
25 mail carrier on the envelope.

26 SEC. 95. Section 14105.33 of the Welfare and Institutions Code
27 is amended to read:

28 14105.33. (a) The department may enter into contracts with
29 manufacturers of single-source and multiple-source drugs, on a
30 bid or nonbid basis, for drugs from each major therapeutic category,
31 and shall maintain a list of those drugs for which contracts have
32 been executed.

33 (b) (1) Contracts executed pursuant to this section shall be for
34 the manufacturer’s best price, as defined in Section 14105.31,
35 which shall be specified in the contract, and subject to agreed-upon
36 price escalators, as defined in that section. The contracts shall
37 provide for ~~an equalization payment amount~~ a state rebate, as
38 defined in Section 14105.31, to be remitted to the department
39 quarterly. The department shall submit an invoice to each
40 manufacturer for the ~~equalization payment amount~~ state rebate,

1 including supporting utilization data from the department's
2 prescription drug paid claims tapes within 30 days of receipt of
3 the *federal* Centers for Medicare and Medicaid Services' file of
4 manufacturer rebate information. In lieu of paying the entire
5 invoiced amount, a manufacturer may contest the invoiced amount
6 pursuant to procedures established by the federal Centers for
7 Medicare and Medicaid Services' Medicaid Drug Rebate Program
8 Releases or regulations by mailing a notice, that shall set forth its
9 grounds for contesting the invoiced amount, to the department
10 within 38 days of the department's mailing of the state invoice
11 and supporting utilization data. For purposes of state accounting
12 practices only, the contested balance shall not be considered an
13 accounts receivable amount until final resolution of the dispute
14 pursuant to procedures established by the federal Centers for
15 Medicare and Medicaid Services' Medicaid Drug Rebate Program
16 Releases or regulations that results in a finding of an underpayment
17 by the manufacturer. Manufacturers may request, and the
18 department shall timely provide, at cost, Medi-Cal provider level
19 drug utilization data, and other Medi-Cal utilization data necessary
20 to resolve a contested department-invoiced rebate amount.

21 (2) The department shall provide for an annual audit of
22 utilization data used to calculate the ~~equalization amount~~ *state*
23 *rebate* to verify the accuracy of that data. The findings of the audit
24 shall be documented in a written audit report to be made available
25 to manufacturers within 90 days of receipt of the report from the
26 auditor. Any manufacturer may receive a copy of the audit report
27 upon written request. Contracts between the department and
28 manufacturers shall provide for any equalization payment
29 adjustments determined necessary pursuant to an audit.

30 (3) Utilization data used to determine ~~an equalization payment~~
31 ~~amount~~ *the state rebate* shall exclude data from both of the
32 following:

33 (A) Health maintenance organizations, as defined in Section
34 300e(a) of Title 42 of the United States Code, including those
35 organizations that contract under Section 1396b(m) of Title 42 of
36 the United States Code.

37 (B) Capitated plans that include a prescription drug benefit in
38 the capitated rate, and that have negotiated contracts for rebates
39 or discounts with manufacturers.

1 (4) ~~Utilization~~ Except as provided in paragraph (3), utilization
2 data used to determine ~~an equalization payment amount~~ the state
3 rebate shall include data from all programs that qualify for federal
4 drug rebates pursuant to Section 1927 of the federal Social Security
5 Act (42 U.S.C. Sec. 1396r-8) or that otherwise qualify for federal
6 funds under Title XIX of the federal Social Security Act (42 U.S.C.
7 Sec. 1396 et seq.) pursuant to the Medicaid state plan or waivers.

8 (c) In order that Medi-Cal beneficiaries may have access to a
9 comprehensive range of therapeutic agents, the department shall
10 ensure that there is representation on the list of contract drugs in
11 all major therapeutic categories. Except as provided in subdivision
12 (a) of Section 14105.35, the department shall not be required to
13 contract with all manufacturers who negotiate for a contract in a
14 particular category. The department shall ensure that there is
15 sufficient representation of single-source and multiple-source
16 drugs, as appropriate, in each major therapeutic category.

17 (d) The department shall select the therapeutic categories to be
18 included on the list of contract drugs, and the order in which it
19 seeks contracts for those categories. The department may establish
20 different contracting schedules for single-source and
21 multiple-source drugs within a given therapeutic category.

22 (e) (1) In order to fully implement subdivision (d), the
23 department shall, to the extent necessary, negotiate or renegotiate
24 contracts to ensure there are as many single-source drugs within
25 each therapeutic category or subcategory as the department
26 determines necessary to meet the health needs of the Medi-Cal
27 population. The department may determine in selected therapeutic
28 categories or subcategories that no single-source drugs are
29 necessary because there are currently sufficient multiple-source
30 drugs in the therapeutic category or subcategory on the list of
31 contract drugs to meet the health needs of the Medi-Cal population.
32 However, in no event shall a beneficiary be denied continued use
33 of a drug which is part of a prescribed therapy in effect as of
34 September 2, 1992, until the prescribed therapy is no longer
35 prescribed.

36 (2) In the development of decisions by the department on the
37 required number of single-source drugs in a therapeutic category
38 or subcategory, and the relative therapeutic merits of each drug in
39 a therapeutic category or subcategory, the department shall consult
40 with the Medi-Cal Contract Drug Advisory Committee. The

1 committee members shall communicate their comments and
2 recommendations to the department within 30 business days of a
3 request for consultation, and shall disclose any associations with
4 pharmaceutical manufacturers or any remuneration from
5 pharmaceutical manufacturers.

6 (f) In order to achieve maximum cost savings, the Legislature
7 declares that an expedited process for contracts under this section
8 is necessary. Therefore, contracts entered into on a nonbid basis
9 shall be exempt from Chapter 2 (commencing with Section 10290)
10 of Part 2 of Division 2 of the Public Contract Code.

11 (g) In no event shall a beneficiary be denied continued use of
12 a drug that is part of a prescribed therapy in effect as of September
13 2, 1992, until the prescribed therapy is no longer prescribed.

14 (h) Contracts executed pursuant to this section shall be
15 confidential and shall be exempt from disclosure under the
16 California Public Records Act (Chapter 3.5 (commencing with
17 Section 6250) of Division 7 of Title 1 of the Government Code).

18 (i) The department shall provide individual notice to Medi-Cal
19 beneficiaries at least 60 calendar days prior to the effective date
20 of the deletion or suspension of any drug from the list of contract
21 drugs. The notice shall include a description of the beneficiary's
22 right to a fair hearing and shall encourage the beneficiary to consult
23 a physician to determine if an appropriate substitute medication
24 is available from Medi-Cal.

25 (j) In carrying out the provisions of this section, the department
26 may contract either directly, or through the fiscal intermediary,
27 for pharmacy consultant staff necessary to initially accomplish the
28 treatment authorization request reviews.

29 (k) (1) Manufacturers shall calculate and pay interest on late
30 or unpaid rebates. The interest shall not apply to any prior period
31 adjustments of unit rebate amounts or department utilization
32 adjustments.

33 (2) For state rebate payments, manufacturers shall calculate and
34 pay interest on late or unpaid rebates for quarters that begin on or
35 after the effective date of the act that added this subdivision.

36 (3) Following final resolution of any dispute pursuant to
37 procedures established by the federal Centers for Medicare and
38 Medicaid Services' Medicaid Drug Rebate Program Releases or
39 regulations regarding the amount of a rebate, any underpayment
40 by a manufacturer shall be paid with interest calculated pursuant

1 to subdivisions (m) and (n), and any overpayment, together with
2 interest at the rate calculated pursuant to subdivisions (m) and (n),
3 shall be credited by the department against future rebates due.

4 (l) Interest pursuant to subdivision (k) shall begin accruing 38
5 calendar days from the date of mailing of the invoice, including
6 supporting utilization data sent to the manufacturer. Interest shall
7 continue to accrue until the date of mailing of the manufacturer's
8 payment.

9 (m) Except as specified in subdivision (n), interest rates and
10 calculations pursuant to subdivision (k) for ~~medicaid~~ *Medicaid*
11 rebates and state rebates shall be identical and shall be determined
12 by the federal Centers for Medicare and Medicaid Services'
13 Medicaid Drug Rebate Program Releases or regulations.

14 (n) If the date of mailing of a state rebate payment is 69 days
15 or more from the date of mailing of the invoice, including
16 supporting utilization data sent to the manufacturer, the interest
17 rate and calculations pursuant to subdivision (k) shall be as
18 specified in subdivision (m), however the interest rate shall be
19 increased by 10 percentage points. This subdivision shall apply to
20 payments for amounts invoiced for any quarters that begin on or
21 after the effective date of the act that added this subdivision.

22 (o) If the rebate payment is not received, the department shall
23 send overdue notices to the manufacturer at 38, 68, and 98 days
24 after the date of mailing of the invoice, and supporting utilization
25 data. If the department has not received a rebate payment, including
26 interest, within 180 days of the date of mailing of the invoice,
27 including supporting utilization data, the manufacturer's contract
28 with the department shall be deemed to be in default and the
29 contract may be terminated in accordance with the terms of the
30 contract. For all other manufacturers, if the department has not
31 received a rebate payment, including interest, within 180 days of
32 the date of mailing of the invoice, including supporting utilization
33 data, all of the drug products of those manufacturers shall be made
34 available only through prior authorization effective 270 days after
35 the date of mailing of the invoice, including utilization data sent
36 to manufacturers.

37 (p) If the manufacturer provides payment or evidence of
38 payment to the department at least 40 days prior to the proposed
39 date the drug is to be made available only through prior
40 authorization pursuant to subdivision (o), the department shall

1 terminate its actions to place the manufacturers' drug products on
2 prior authorization.

3 (q) The department shall direct the state's fiscal intermediary
4 to remove prior authorization requirements imposed pursuant to
5 subdivision (o) and notify providers within 60 days after payment
6 by the manufacturer of the rebate, including interest. If a contract
7 was in place at the time the manufacturers' drugs were placed on
8 prior authorization, removal of prior authorization requirements
9 shall be contingent upon good faith negotiations and a signed
10 contract with the department.

11 (r) A beneficiary may obtain drugs placed on prior authorization
12 pursuant to subdivision (o) if the beneficiary qualifies for
13 continuing care status. To be eligible for continuing care status, a
14 beneficiary must be taking the drug when its manufacturer is placed
15 on prior authorization status. Additionally, the department shall
16 have received a claim for the drug with a date of service that is
17 within 100 days prior to the date the manufacturer was placed on
18 prior authorization.

19 (s) A beneficiary may remain eligible for continuing care status,
20 provided that a claim is submitted for the drug in question at least
21 every 100 days and the date of service of the claim is within 100
22 days of the date of service of the last claim submitted for the same
23 drug.

24 (t) Drugs covered pursuant to Sections 14105.43 and 14133.2
25 shall not be subject to prior authorization pursuant to subdivision
26 (o), and any other drug may be exempted from prior authorization
27 by the department if the director determines that an essential need
28 exists for that drug, and there are no other drugs currently available
29 without prior authorization that meet that need.

30 (u) It is the intent of the Legislature in enacting subdivisions
31 (k) to (t), inclusive, that the department and manufacturers shall
32 cooperate and make every effort to resolve rebate payment disputes
33 within 90 days of notification by the manufacturer to the
34 department of a dispute in the calculation of rebate payments.

35 *SEC. 96. Section 14105.332 of the Welfare and Institutions*
36 *Code is amended to read:*

37 14105.332. State and federal rebates that are owed to the state
38 for drugs dispensed to ~~fee-for-service~~ Medi-Cal beneficiaries shall
39 not be reduced to the state if a manufacturer reports, to the *federal*
40 Centers for Medicare and Medicaid Services or the department, a

1 revised drug product's average manufacturer price or best price
2 as these terms are defined pursuant to Section 1927 of the federal
3 Social Security Act (42 U.S.C. Sec. 1396r-8) for any calendar
4 quarter in which the rebate was due.

5 *SEC. 97. Section 14105.34 of the Welfare and Institutions Code*
6 *is amended to read:*

7 14105.34. (a) The department shall provide for an annual
8 written report of Medi-Cal pharmacy costs or Medi-Cal drug costs,
9 as defined in subdivision ~~(f)~~ (e) of Section 14105.31.

10 (b) The annual report shall be consistent with the relevant
11 sections of the Quarterly Report of Expenditures for the Medi-Cal
12 Assistance Program, known as the ~~HCFA-64 CMS-64~~ Report,
13 provided to the federal Centers for Medicare and Medicaid
14 Services. The report shall include the following expenditure and
15 receipt information:

16 (1) The total annual ~~equalization payment~~ *rebate* amounts
17 received by the department pursuant to agreements with the federal
18 Centers for Medicare and Medicaid Services of the United States
19 Department of Health and Human Services.

20 (2) The total annual ~~equalization payment~~ *rebate* amounts
21 received pursuant to state contracts with drug manufacturers.

22 (3) Total drug cost amounts upon which ~~equalization~~ *rebate*
23 payments were made.

24 *SEC. 97.5. Section 14105.451 is added to the Welfare and*
25 *Institutions Code, to read:*

26 14105.451. (a) (1) *The Legislature finds and declares all of*
27 *the following:*

28 (A) *The United States Department of Health and Human*
29 *Services has identified the critical need for state Medicaid agencies*
30 *to establish pharmacy reimbursement rates based on a pricing*
31 *benchmark that reflects actual acquisition costs.*

32 (B) *The Medi-Cal program currently uses a methodology based*
33 *on average wholesale price.*

34 (C) *Investigations by the federal Office of Inspector General*
35 *have found that average wholesale price is inflated relative to*
36 *average acquisition cost.*

37 (2) *Therefore, it is the intent of the Legislature to enact*
38 *legislation by August 1, 2011, that provides for development of a*
39 *new reimbursement methodology that will enable the department*

1 to achieve savings while continuing to reimburse pharmacy
2 providers in compliance with federal law.

3 (b) The department may require providers, manufacturers, and
4 wholesalers to submit any data the director determines necessary
5 or useful in preparing for the transition from a methodology based
6 on average wholesale price to a methodology based on actual
7 acquisition cost.

8 SEC. 98. Section 14126.033 of the Welfare and Institutions
9 Code is amended to read:

10 14126.033. (a) ~~This~~ The Legislature finds and declares all of
11 the following:

12 (1) Costs within the Medi-Cal program continue to grow due
13 to the rising cost of providing health care throughout the state and
14 also due to increases in enrollment, which are more pronounced
15 during difficult economic times.

16 (2) In order to minimize the need for drastically cutting
17 enrollment standards or benefits during times of economic crisis,
18 it is crucial to find areas within the program where reimbursement
19 levels are higher than required under the standard provided in
20 Section 1902(a)(30)(A) of the federal Social Security Act and can
21 be reduced in accordance with federal law.

22 (3) The Medi-Cal program delivers its services and benefits to
23 Medi-Cal beneficiaries through a wide variety of health care
24 providers, some of which deliver care via managed care or other
25 contract models while others do so through fee-for-service
26 arrangements.

27 (4) The setting of rates within the Medi-Cal program is complex
28 and is subject to close supervision by the United States Department
29 of Health and Human Services.

30 (5) As the single state agency for Medicaid in California, the
31 State Department of Health Care Services has unique expertise
32 that can inform decisions that set or adjust reimbursement
33 methodologies and levels consistent with the requirements of
34 federal law.

35 (b) Therefore, it is the intent of the Legislature for the
36 department to analyze and identify where reimbursement levels
37 can be reduced consistent with the standard provided in Section
38 1902(a)(30)(A) of the federal Social Security Act and also
39 consistent with federal and state law and policies, including any
40 exemptions contained in the act that added this section, provided

1 *that the reductions in reimbursement shall not exceed 10 percent*
2 *on an aggregate basis for all providers, services, and products.*

3 (c) *This article, including Section 14126.031, shall be funded*
4 *as follows:*

5 (1) General Fund moneys appropriated for purposes of this
6 article pursuant to Section 6 of the act adding this section shall be
7 used for increasing rates, except as provided in Section 14126.031,
8 for freestanding skilled nursing facilities, and shall be consistent
9 with the approved methodology required to be submitted to the
10 federal Centers for Medicare and Medicaid Services pursuant to
11 Article 7.6 (commencing with Section 1324.20) of Chapter 2 of
12 Division 2 of the Health and Safety Code.

13 (2) (A) Notwithstanding Section 14126.023, for the 2005–06
14 rate year, the maximum annual increase in the weighted average
15 Medi-Cal rate required for purposes of this article shall not exceed
16 8 percent of the weighted average Medi-Cal reimbursement rate
17 for the 2004–05 rate year as adjusted for the change in the cost to
18 the facility to comply with the nursing facility quality assurance
19 fee for the 2005–06 rate year, as required under subdivision (b) of
20 Section 1324.21 of the Health and Safety Code, plus the total
21 projected Medi-Cal cost to the facility of complying with new state
22 or federal mandates.

23 (B) Beginning with the 2006–07 rate year, the maximum annual
24 increase in the weighted average Medi-Cal reimbursement rate
25 required for purposes of this article shall not exceed 5 percent of
26 the weighted average Medi-Cal reimbursement rate for the prior
27 fiscal year, as adjusted for the projected cost of complying with
28 new state or federal mandates.

29 (C) Beginning with the 2007–08 rate year and continuing
30 through the 2008–09 rate year, the maximum annual increase in
31 the weighted average Medi-Cal reimbursement rate required for
32 purposes of this article shall not exceed 5.5 percent of the weighted
33 average Medi-Cal reimbursement rate for the prior fiscal year, as
34 adjusted for the projected cost of complying with new state or
35 federal mandates.

36 (D) For the 2009–10 rate year, the weighted average Medi-Cal
37 reimbursement rate required for purposes of this article shall not
38 be increased with respect to the weighted average Medi-Cal
39 reimbursement rate for the 2008–09 rate year, as adjusted for the
40 projected cost of complying with new state or federal mandates.

(3) (A) For the 2010–11 rate year, if the increase in the federal medical assistance percentage (FMAP) pursuant to the federal American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5) is extended for the entire 2010–11 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purposes of this article shall not exceed 3.93 percent, or 3.14 percent, if the increase in the FMAP pursuant to ARRA is not extended for that period of time, plus the projected cost of complying with new state or federal mandates. If the increase in the FMAP pursuant to ARRA is extended at a different rate, or for a different time period, the rate adjustment for facilities shall be adjusted accordingly.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) If the federal Centers for Medicare and Medicaid Services does not approve exemption changes to the facilities subject to the quality assurance fee.

(ii) If the federal Centers for Medicare and Medicaid Services does not approve any proposed modification to the methodology for calculation of the quality assurance fee.

(iii) To ensure that the state does not incur any additional General Fund expenses to pay for the 2010–11 weighted average Medi-Cal reimbursement rate increase.

(C) If the maximum annual increase in the weighted average Medi-Cal rate is reduced pursuant to subparagraph (B), the department shall recalculate and publish the final maximum annual increase in the weighted average Medi-Cal reimbursement rate.

(4) (A) Subject to the following provisions, for the 2011–12 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate for the purpose of this article shall not exceed 2.4 percent, plus the projected cost of complying with new state or federal ~~mandate~~ *mandates*.

(B) The weighted average Medi-Cal reimbursement rate increase specified in subparagraph (A) shall be adjusted by the department for the following reasons:

(i) For the 2011–12 rate year, the department shall set aside 1 percent of the weighted average Medi-Cal reimbursement rate, from which the department shall transfer the General Fund portion

1 into the Skilled Nursing Facility Quality and Accountability Special
2 Fund, to be used for the supplemental rate pool.

3 (ii) If the federal Centers for Medicare and Medicaid Services
4 does not approve exemption changes to the facilities subject to the
5 quality assurance fee.

6 (iii) If the federal Centers for Medicare and Medicaid Services
7 does not approve any proposed modification to the methodology
8 for calculation of the quality assurance fee.

9 (iv) To ensure that the state does not incur any additional
10 General Fund expenses to pay for the 2011–12 weighted average
11 Medi-Cal reimbursement rate increase.

12 (C) The department may recalculate and publish the weighted
13 average Medi-Cal reimbursement rate increase for the 2011–12
14 rate year if the difference in the projected quality assurance fee
15 collections from the 2011–12 rate year, compared to the projected
16 quality assurance fee collections for the 2010–11 rate year, would
17 result in any additional General Fund expense to pay for the
18 2011–12 rate year weighted average reimbursement rate increase.

19 (5) To the extent that rates are projected to exceed the adjusted
20 limits calculated pursuant to subparagraphs (A) to (D), inclusive,
21 of paragraph (2) and, as applicable, paragraphs (3) and (4), the
22 department shall adjust each skilled nursing facility's projected
23 rate for the applicable rate year by an equal percentage.

24 (6) (A) (i) *Notwithstanding any other provision of law, and*
25 *except as provided in subparagraphs (B), (C), and (D), payments*
26 *resulting from the application of paragraphs (3) and (4), the*
27 *provisions of paragraph (5), and all other applicable adjustments*
28 *and limits as required by this section, shall be reduced by 10*
29 *percent for dates of service on and after June 1, 2011.*

30 (ii) *Notwithstanding any other provision of law, the director*
31 *may adjust the percentage reductions specified in clause (i), as*
32 *long as the resulting reductions, in the aggregate, total no more*
33 *than 10 percent.*

34 (iii) *The adjustments authorized under this subparagraph shall*
35 *be implemented only if the director determines that the payments*
36 *resulting from the adjustments comply with paragraph (7).*

37 (B) *Notwithstanding any other provision of law, the 1 percent*
38 *set aside of the weighted average Medi-Cal reimbursement rate*
39 *as required by clause (i) of subparagraph (B) of paragraph (4)*

1 *shall be exempt from the payment reduction required by this*
2 *paragraph.*

3 *(C) Notwithstanding any other provision of law, payments to*
4 *skilled nursing facilities pursuant to subdivision (m) of Section*
5 *14126.022 shall be exempt from the payment reduction required*
6 *by this paragraph.*

7 *(D) Payments to facilities owned or operated by the state shall*
8 *be exempt from the payment reduction required by this paragraph.*

9 *(7) (A) Notwithstanding any other provision of this section, the*
10 *payment reductions and adjustments required by paragraph (6)*
11 *shall be implemented only if the director determines that the*
12 *payments that result from the application of paragraph (6) will*
13 *comply with applicable federal Medicaid requirements and that*
14 *federal financial participation will be available.*

15 *(B) In determining whether federal financial participation is*
16 *available, the director shall determine whether the payments*
17 *comply with applicable federal Medicaid requirements, including*
18 *those set forth in Section 1396a(a)(30)(A) of Title 42 of the United*
19 *States Code.*

20 *(C) To the extent that the director determines that the payments*
21 *do not comply with applicable federal Medicaid requirements or*
22 *that federal financial participation is not available with respect*
23 *to any payment that is reduced pursuant to this section, the director*
24 *retains the discretion to not implement the particular payment*
25 *reduction or adjustment and may adjust the payment as necessary*
26 *to comply with federal Medicaid requirements.*

27 *(8) For managed care health plans that contract with the*
28 *department pursuant to this chapter and Chapter 8 (commencing*
29 *with Section 14200), except for contracts with the Senior Care*
30 *Action Network and AIDS Healthcare Foundation, and to the*
31 *extent that these services are provided through any of those*
32 *contracts, payments shall be reduced by the actuarial equivalent*
33 *amount of the reduced provider reimbursements specified in*
34 *paragraph (6) pursuant to contract amendments or change orders*
35 *effective on July 1, 2011, or thereafter.*

36 *(9) The director shall seek any necessary federal approvals for*
37 *the implementation of this section. This section shall not be*
38 *implemented until federal approval is obtained. When federal*
39 *approval is obtained, the payments resulting from the application*

1 *of paragraph (6) shall be implemented retroactively to June 1,*
2 *2011, or on any other date or dates as may be applicable.*

3 ~~(b)~~

4 (d) The rate methodology shall cease to be implemented after
5 July 31, 2012.

6 ~~(e)~~

7 (e) (1) It is the intent of the Legislature that the implementation
8 of this article result in individual access to appropriate long-term
9 care services, quality resident care, decent wages and benefits for
10 nursing home workers, a stable workforce, provider compliance
11 with all applicable state and federal requirements, and
12 administrative efficiency.

13 (2) Not later than December 1, 2006, the Bureau of State Audits
14 shall conduct an accountability evaluation of the department's
15 progress toward implementing a facility-specific reimbursement
16 system, including a review of data to ensure that the new system
17 is appropriately reimbursing facilities within specified cost
18 categories and a review of the fiscal impact of the new system on
19 the General Fund.

20 (3) Not later than January 1, 2007, to the extent information is
21 available for the three years immediately preceding the
22 implementation of this article, the department shall provide baseline
23 information in a report to the Legislature on all of the following:

24 (A) The number and percent of freestanding skilled nursing
25 facilities that complied with minimum staffing requirements.

26 (B) The staffing levels prior to the implementation of this article.

27 (C) The staffing retention rates prior to the implementation of
28 this article.

29 (D) The numbers and percentage of freestanding skilled nursing
30 facilities with findings of immediate jeopardy, substandard quality
31 of care, or actual harm, as determined by the certification survey
32 of each freestanding skilled nursing facility conducted prior to the
33 implementation of this article.

34 (E) The number of freestanding skilled nursing facilities that
35 received state citations and the number and class of citations issued
36 during calendar year 2004.

37 (F) The average wage and benefits for employees prior to the
38 implementation of this article.

39 (4) Not later than January 1, 2009, the department shall provide
40 a report to the Legislature that does both of the following:

1 (A) Compares the information required in paragraph (2) to that
2 same information two years after the implementation of this article.

3 (B) Reports on the extent to which residents who had expressed
4 a preference to return to the community, as provided in Section
5 1418.81 of the Health and Safety Code, were able to return to the
6 community.

7 (5) The department may contract for the reports required under
8 this subdivision.

9 ~~(d) This article shall become inoperative after July 31, 2012,~~
10 ~~and as of January 1, 2013, is repealed, unless a later enacted statute,~~
11 ~~that is enacted before January 1, 2013, deletes or extends the dates~~
12 ~~on which it becomes inoperative and is repealed.~~

13 SEC. 99. Section 14126.036 is added to the Welfare and
14 Institutions Code, to read:

15 14126.036. This article shall become inoperative on August 1,
16 2012, and as of January 1, 2013 is repealed, unless a later enacted
17 statute that is enacted before January 1, 2013, deletes or extends
18 that date.

19 SEC. 100. Section 14131.05 is added to the Welfare and
20 Institutions Code, to read:

21 14131.05. (a) Notwithstanding any other provision of this
22 chapter or Chapter 8 (commencing with Section 14200), optional
23 hearing aid benefits are subject to per beneficiary benefit cap
24 amounts under the Medi-Cal program.

25 (b) For the purposes of this section, "benefit cap amount" means
26 the maximum amount of Medi-Cal coverage for optional hearing
27 aid benefits as specified in subdivision (c), for each beneficiary,
28 for each fiscal year.

29 (c) Hearing aid benefits are subject to a benefit cap amount of
30 one thousand five hundred ten dollars (\$1,510).

31 (d) Pregnancy-related benefits and benefits for the treatment
32 of other conditions that might complicate the pregnancy are not
33 subject to the benefit cap amount in subdivision (c).

34 (e) The benefit cap amount in subdivision (c) does not apply to
35 the following:

36 (1) Beneficiaries under the Early and Periodic Screening,
37 Diagnosis, and Treatment Program.

38 (2) Beneficiaries receiving long-term care in a nursing facility
39 that is both of the following:

1 (A) A skilled nursing facility or intermediate care facility as
2 defined in subdivisions (c), (d), (e), (g), and (h), respectively, of
3 Section 1250 of the Health and Safety Code, and facilities
4 providing continuous skilled nursing care to developmentally
5 disabled individuals pursuant to the program established by Section
6 14132.20.

7 (B) A licensed nursing facility pursuant to subdivision (k) of
8 Section 1250 of the Health and Safety Code.

9 (f) For managed care health plans that contract with the
10 department pursuant to this chapter or Chapter 8 (commencing
11 with Section 14200), except for contracts with the Senior Care
12 Action Network and AIDS Healthcare Foundation, payments for
13 optional hearing aid benefits shall be reduced by the actuarial
14 equivalent amount of the benefit reductions resulting from the
15 implementation of the benefit cap amount specified in this section
16 pursuant to contract amendments or change orders effective on
17 July 1, 2011, or any date thereafter.

18 (g) This section shall be implemented only to the extent permitted
19 by federal law.

20 (h) Notwithstanding the rulemaking provisions of the
21 Administrative Procedure Act (Chapter 3.5 (commencing with
22 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
23 Code), the department may implement the provisions of this section
24 by means of all-county letters, provider bulletins, or similar
25 instructions, without taking further regulatory action.

26 (i) This section shall be implemented on the first day of the first
27 calendar month following 210 days after the effective date of this
28 section, or on the first day of the first calendar month following
29 60 days after the date the department secures all necessary federal
30 approvals to implement this section, whichever is later. If the
31 implementation date occurs after July 1, 2011, then the benefit
32 cap described in subdivision (c) for the first year of implementation
33 shall be applied from the implementation date through June 30 of
34 the state fiscal year in which implementation commences.
35 Thereafter, the benefit cap shall apply on a state fiscal year basis.

36 SECTION 100.5. Section 14131.07 is added to the Welfare and
37 Institutions Code, to read:

38 14131.07. (a) Notwithstanding any other provision of this
39 chapter or Chapter 8 (commencing with Section 14200), the total
40 number of physician office and clinic visits for physician services

1 provided by a physician, or under the direction of a physician,
2 that are a covered benefit under the Medi-Cal program shall be
3 limited to seven visits per beneficiary per fiscal year, excepting
4 visits that meet the conditions set forth in subdivision (b). For
5 purposes of this limit, a visit shall include physician services
6 provided at any federally qualified health center, rural health
7 clinic, community clinic, outpatient clinic, and hospital outpatient
8 department. The department may seek input from consumer
9 organizations and the provider community, as applicable, prior
10 to implementation.

11 (b) (1) Visits exceeding seven per beneficiary per fiscal year
12 shall be required to be certified by the physician, or other medical
13 professional under the supervision of a physician, attesting that
14 one or more of the following circumstances is applicable:

15 (A) The services will prevent deterioration in a beneficiary's
16 condition that would otherwise foreseeably result in admission to
17 the emergency department.

18 (B) The services will prevent deterioration in the beneficiary's
19 condition that would otherwise result in inpatient admission.

20 (C) The services will prevent disruption in ongoing medical
21 therapy or surgical therapy, or both, including, but not limited to,
22 medications, radiation, or wound management.

23 (D) The services constitute diagnostic workup in progress that
24 would otherwise foreseeably result in inpatient or emergency
25 department admission.

26 (E) The services are for the purpose of assessment and form
27 completion for Medi-Cal recipients seeking or receiving in-home
28 supportive services.

29 (2) The certification shall consist of a written declaration by
30 the physician, or other medical professional under the supervision
31 of the physician, that the visit meets the requirements of any one
32 or more of the circumstances set forth in paragraph (1), and shall
33 include a description of the services provided.

34 (3) The certification shall be maintained onsite at the physician's
35 office or clinic location at which the medical records for the
36 beneficiary are maintained and shall be subject to audit and
37 inspection by the department.

38 (4) This subdivision does not authorize or direct a beneficiary
39 to obtain services at a physician office or clinic visit for an

1 *emergency medical condition or that should properly be provided*
2 *in the emergency department or as hospital inpatient services.*

3 *(c) Specialty mental health services furnished or arranged for*
4 *the provision of mental health services to Medi-Cal beneficiaries*
5 *pursuant to Part 2.5 (commencing with Section 5775) of Division*
6 *5, shall not be subject to the limit provided in subdivision (a).*

7 *(d) Any pregnancy-related visit, or any visit for the treatment*
8 *of any other condition that might complicate a pregnancy, shall*
9 *not be subject to the limit provided in subdivision (a).*

10 *(e) The limit on physician office and clinic visits provided in*
11 *subdivision (a) shall not apply to any of the following:*

12 *(1) A beneficiary under the Early and Periodic Screening,*
13 *Diagnosis, and Treatment (EPSDT) Program.*

14 *(2) A beneficiary receiving long-term care in a nursing facility*
15 *that is both of the following:*

16 *(A) A skilled nursing facility or intermediate care facility as*
17 *defined in subdivisions (c), (d), (e), (g), and (h), respectively, of*
18 *Section 1250 of the Health and Safety Code, and facilities*
19 *providing continuous skilled nursing care to persons with*
20 *developmental disabilities under the pilot project established*
21 *pursuant to Section 14132.20.*

22 *(B) Licensed pursuant to subdivision (k) of Section 1250 of the*
23 *Health and Safety Code.*

24 *(f) For managed health care plans that contract with the*
25 *department pursuant to this chapter or Chapter 8 (commencing*
26 *with Section 14200), except for Senior Care Action Network or*
27 *AIDS Healthcare Foundation, payments shall be reduced by the*
28 *actuarial equivalent amount of the benefit reductions resulting*
29 *from the implementation of the benefit cap amounts specified in*
30 *this section pursuant to contract amendments or change orders*
31 *effective on July 1, 2011, or thereafter.*

32 *(g) This section shall be implemented only to the extent permitted*
33 *by federal law.*

34 *(h) Notwithstanding Chapter 3.5 (commencing with Section*
35 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
36 *the department may implement this section by means of all-county*
37 *letters, provider bulletins, or similar instructions, without taking*
38 *regulatory action.*

39 *(i) This section shall be implemented on the first day of the first*
40 *calendar month following 180 days after the effective date of the*

1 *act that added this section, or on the first day of the calendar month*
2 *following 60 days after the date the department secures all*
3 *necessary federal approvals to implement this section, whichever*
4 *is later. If the implementation date occurs after July 1, 2011, then*
5 *the benefit caps described in subdivision (a) for the first year of*
6 *implementation shall be applied from the implementation date to*
7 *June 30 of the state fiscal year in which implementation begins.*
8 *Thereafter, the benefit caps shall apply on a state fiscal year basis.*

9 *SEC. 101. Section 14132 of the Welfare and Institutions Code*
10 *is amended to read:*

11 14132. The following is the schedule of benefits under this
12 chapter:

13 (a) Outpatient services are covered as follows:

14 Physician, hospital or clinic outpatient, surgical center,
15 respiratory care, optometric, chiropractic, psychology, podiatric,
16 occupational therapy, physical therapy, speech therapy, audiology,
17 acupuncture to the extent federal matching funds are provided for
18 acupuncture, and services of persons rendering treatment by prayer
19 or healing by spiritual means in the practice of any church or
20 religious denomination insofar as these can be encompassed by
21 federal participation under an approved plan, subject to utilization
22 controls.

23 (b) Inpatient hospital services, including, but not limited to,
24 physician and podiatric services, physical therapy and occupational
25 therapy, are covered subject to utilization controls.

26 (c) Nursing facility services, subacute care services, and services
27 provided by any category of intermediate care facility for the
28 developmentally disabled, including podiatry, physician, nurse
29 practitioner services, and prescribed drugs, as described in
30 subdivision (d), are covered subject to utilization controls.
31 Respiratory care, physical therapy, occupational therapy, speech
32 therapy, and audiology services for patients in nursing facilities
33 and any category of intermediate care facility for the
34 developmentally disabled are covered subject to utilization controls.

35 (d) (1) Purchase of prescribed drugs is covered subject to the
36 Medi-Cal List of Contract Drugs and utilization controls.

37 (2) Purchase of drugs used to treat erectile dysfunction or any
38 off-label uses of those drugs are covered only to the extent that
39 federal financial participation is available.

1 (3) (A) To the extent required by federal law, the purchase of
2 outpatient prescribed drugs, for which the prescription is executed
3 by a prescriber in written, nonelectronic form on or after April 1,
4 2008, is covered only when executed on a tamper resistant
5 prescription form. The implementation of this paragraph shall
6 conform to the guidance issued by the federal Centers of Medicare
7 and Medicaid Services but shall not conflict with state statutes on
8 the characteristics of tamper resistant prescriptions for controlled
9 substances, including Section 11162.1 of the Health and Safety
10 Code. The department shall provide providers and beneficiaries
11 with as much flexibility in implementing these rules as allowed
12 by the federal government. The department shall notify and consult
13 with appropriate stakeholders in implementing, interpreting, or
14 making specific this paragraph.

15 (B) Notwithstanding Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 the department may take the actions specified in subparagraph (A)
18 by means of a provider bulletin or notice, policy letter, or other
19 similar instructions without taking regulatory action.

20 (4) (A) ~~Nonlegend acetaminophen-containing products, with~~
21 ~~the exception of children's Tylenol, selected by the department~~
22 ~~are not covered benefits.~~ (i) For the purposes of this paragraph,
23 nonlegend has the same meaning as defined in subdivision (a) of
24 Section 14105.45.

25 (ii) *Nonlegend acetaminophen-containing products, with the*
26 *exception of children's acetaminophen-containing products,*
27 *selected by the department are not covered benefits.*

28 (iii) *Nonlegend cough and cold products selected by the*
29 *department are not covered benefits. This clause shall be*
30 *implemented on the first day of the first calendar month following*
31 *90 days after the effective date of the act that added this clause,*
32 *or on the first day of the first calendar month following 60 days*
33 *after the date the department secures all necessary federal*
34 *approvals to implement this section, whichever is later.*

35 (iv) *Beneficiaries under the Early and Periodic Screening,*
36 *Diagnosis, and Treatment Program shall be exempt from clauses*
37 *(ii) and (iii).*

38 (B) Notwithstanding Chapter 3.5 (commencing with Section
39 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
40 the department may take the actions specified in subparagraph (A)

1 by means of a provider bulletin or notice, policy letter, or other
2 similar instruction without taking regulatory action.

3 (e) Outpatient dialysis services and home hemodialysis services,
4 including physician services, medical supplies, drugs and
5 equipment required for dialysis, are covered, subject to utilization
6 controls.

7 (f) Anesthesiologist services when provided as part of an
8 outpatient medical procedure, nurse anesthetist services when
9 rendered in an inpatient or outpatient setting under conditions set
10 forth by the director, outpatient laboratory services, and X-ray
11 services are covered, subject to utilization controls. Nothing in
12 this subdivision shall be construed to require prior authorization
13 for anesthesiologist services provided as part of an outpatient
14 medical procedure or for portable X-ray services in a nursing
15 facility or any category of intermediate care facility for the
16 developmentally disabled.

17 (g) Blood and blood derivatives are covered.

18 (h) (1) Emergency and essential diagnostic and restorative
19 dental services, except for orthodontic, fixed bridgework, and
20 partial dentures that are not necessary for balance of a complete
21 artificial denture, are covered, subject to utilization controls. The
22 utilization controls shall allow emergency and essential diagnostic
23 and restorative dental services and prostheses that are necessary
24 to prevent a significant disability or to replace previously furnished
25 prostheses which are lost or destroyed due to circumstances beyond
26 the beneficiary's control. Notwithstanding the foregoing, the
27 director may by regulation provide for certain fixed artificial
28 dentures necessary for obtaining employment or for medical
29 conditions that preclude the use of removable dental prostheses,
30 and for orthodontic services in cleft palate deformities administered
31 by the department's California Children Services Program.

32 (2) For persons 21 years of age or older, the services specified
33 in paragraph (1) shall be provided subject to the following
34 conditions:

35 (A) Periodontal treatment is not a benefit.

36 (B) Endodontic therapy is not a benefit except for vital
37 pulpotomy.

38 (C) Laboratory processed crowns are not a benefit.

39 (D) Removable prosthetics shall be a benefit only for patients
40 as a requirement for employment.

1 (E) The director may, by regulation, provide for the provision
2 of fixed artificial dentures that are necessary for medical conditions
3 that preclude the use of removable dental prostheses.

4 (F) Notwithstanding the conditions specified in subparagraphs
5 (A) to (E), inclusive, the department may approve services for
6 persons with special medical disorders subject to utilization review.

7 (3) Paragraph (2) shall become inoperative July 1, 1995.

8 (i) Medical transportation is covered, subject to utilization
9 controls.

10 (j) Home health care services are covered, subject to utilization
11 controls.

12 (k) Prosthetic and orthotic devices and eyeglasses are covered,
13 subject to utilization controls. Utilization controls shall allow
14 replacement of prosthetic and orthotic devices and eyeglasses
15 necessary because of loss or destruction due to circumstances
16 beyond the beneficiary's control. Frame styles for eyeglasses
17 replaced pursuant to this subdivision shall not change more than
18 once every two years, unless the department so directs.

19 Orthopedic and conventional shoes are covered when provided
20 by a prosthetic and orthotic supplier on the prescription of a
21 physician and when at least one of the shoes will be attached to a
22 prosthesis or brace, subject to utilization controls. Modification
23 of stock conventional or orthopedic shoes when medically
24 indicated, is covered subject to utilization controls. When there is
25 a clearly established medical need that cannot be satisfied by the
26 modification of stock conventional or orthopedic shoes,
27 custom-made orthopedic shoes are covered, subject to utilization
28 controls.

29 Therapeutic shoes and inserts are covered when provided to
30 beneficiaries with a diagnosis of diabetes, subject to utilization
31 controls, to the extent that federal financial participation is
32 available.

33 (l) Hearing aids are covered, subject to utilization controls.
34 Utilization controls shall allow replacement of hearing aids
35 necessary because of loss or destruction due to circumstances
36 beyond the beneficiary's control.

37 (m) Durable medical equipment and medical supplies are
38 covered, subject to utilization controls. The utilization controls
39 shall allow the replacement of durable medical equipment and
40 medical supplies when necessary because of loss or destruction

1 due to circumstances beyond the beneficiary's control. The
2 utilization controls shall allow authorization of durable medical
3 equipment needed to assist a disabled beneficiary in caring for a
4 child for whom the disabled beneficiary is a parent, stepparent,
5 foster parent, or legal guardian, subject to the availability of federal
6 financial participation. The department shall adopt emergency
7 regulations to define and establish criteria for assistive durable
8 medical equipment in accordance with the rulemaking provisions
9 of the Administrative Procedure Act (Chapter 3.5 (commencing
10 with Section 11340) of Part 1 of Division 3 of Title 2 of the
11 Government Code).

12 (n) Family planning services are covered, subject to utilization
13 controls.

14 (o) Inpatient intensive rehabilitation hospital services, including
15 respiratory rehabilitation services, in a general acute care hospital
16 are covered, subject to utilization controls, when either of the
17 following criteria are met:

18 (1) A patient with a permanent disability or severe impairment
19 requires an inpatient intensive rehabilitation hospital program as
20 described in Section 14064 to develop function beyond the limited
21 amount that would occur in the normal course of recovery.

22 (2) A patient with a chronic or progressive disease requires an
23 inpatient intensive rehabilitation hospital program as described in
24 Section 14064 to maintain the patient's present functional level as
25 long as possible.

26 (p) (1) Adult day health care is covered in accordance with
27 Chapter 8.7 (commencing with Section 14520).

28 (2) Commencing 30 days after the effective date of the act that
29 added this paragraph, and notwithstanding the number of days
30 previously approved through a treatment authorization request,
31 adult day health care is covered for a maximum of three days per
32 week.

33 (3) As provided in accordance with paragraph (4), adult day
34 health care is covered for a maximum of five days per week.

35 (4) As of the date that the director makes the declaration
36 described in subdivision (g) of Section 14525.1, paragraph (2)
37 shall become inoperative and paragraph (3) shall become operative.

38 (q) (1) Application of fluoride, or other appropriate fluoride
39 treatment as defined by the department, other prophylaxis treatment
40 for children 17 years of age and under, are covered.

1 (2) All dental hygiene services provided by a registered dental
2 hygienist in alternative practice pursuant to Sections 1768 and
3 1770 of the Business and Professions Code may be covered as
4 long as they are within the scope of Denti-Cal benefits and they
5 are necessary services provided by a registered dental hygienist
6 in alternative practice.

7 (r) (1) Paramedic services performed by a city, county, or
8 special district, or pursuant to a contract with a city, county, or
9 special district, and pursuant to a program established under Article
10 3 (commencing with Section 1480) of Chapter 2.5 of Division 2
11 of the Health and Safety Code by a paramedic certified pursuant
12 to that article, and consisting of defibrillation and those services
13 specified in subdivision (3) of Section 1482 of the article.

14 (2) All providers enrolled under this subdivision shall satisfy
15 all applicable statutory and regulatory requirements for becoming
16 a Medi-Cal provider.

17 (3) This subdivision shall be implemented only to the extent
18 funding is available under Section 14106.6.

19 (s) In-home medical care services are covered when medically
20 appropriate and subject to utilization controls, for beneficiaries
21 who would otherwise require care for an extended period of time
22 in an acute care hospital at a cost higher than in-home medical
23 care services. The director shall have the authority under this
24 section to contract with organizations qualified to provide in-home
25 medical care services to those persons. These services may be
26 provided to patients placed in shared or congregate living
27 arrangements, if a home setting is not medically appropriate or
28 available to the beneficiary. As used in this section, "in-home
29 medical care service" includes utility bills directly attributable to
30 continuous, 24-hour operation of life-sustaining medical equipment,
31 to the extent that federal financial participation is available.

32 As used in this subdivision, in-home medical care services,
33 include, but are not limited to:

34 (1) Level of care and cost of care evaluations.

35 (2) Expenses, directly attributable to home care activities, for
36 materials.

37 (3) Physician fees for home visits.

38 (4) Expenses directly attributable to home care activities for
39 shelter and modification to shelter.

- 1 (5) Expenses directly attributable to additional costs of special
- 2 diets, including tube feeding.
- 3 (6) Medically related personal services.
- 4 (7) Home nursing education.
- 5 (8) Emergency maintenance repair.
- 6 (9) Home health agency personnel benefits which permit
- 7 coverage of care during periods when regular personnel are on
- 8 vacation or using sick leave.
- 9 (10) All services needed to maintain antiseptic conditions at
- 10 stoma or shunt sites on the body.
- 11 (11) Emergency and nonemergency medical transportation.
- 12 (12) Medical supplies.
- 13 (13) Medical equipment, including, but not limited to, scales,
- 14 gurneys, and equipment racks suitable for paralyzed patients.
- 15 (14) Utility use directly attributable to the requirements of home
- 16 care activities which are in addition to normal utility use.
- 17 (15) Special drugs and medications.
- 18 (16) Home health agency supervision of visiting staff which is
- 19 medically necessary, but not included in the home health agency
- 20 rate.
- 21 (17) Therapy services.
- 22 (18) Household appliances and household utensil costs directly
- 23 attributable to home care activities.
- 24 (19) Modification of medical equipment for home use.
- 25 (20) Training and orientation for use of life-support systems,
- 26 including, but not limited to, support of respiratory functions.
- 27 (21) Respiratory care practitioner services as defined in Sections
- 28 3702 and 3703 of the Business and Professions Code, subject to
- 29 prescription by a physician and surgeon.
- 30 Beneficiaries receiving in-home medical care services are entitled
- 31 to the full range of services within the Medi-Cal scope of benefits
- 32 as defined by this section, subject to medical necessity and
- 33 applicable utilization control. Services provided pursuant to this
- 34 subdivision, which are not otherwise included in the Medi-Cal
- 35 schedule of benefits, shall be available only to the extent that
- 36 federal financial participation for these services is available in
- 37 accordance with a home- and community-based services waiver.
- 38 (t) Home- and community-based services approved by the
- 39 United States Department of Health and Human Services may be
- 40 covered to the extent that federal financial participation is available

1 for those services under waivers granted in accordance with Section
2 1396n of Title 42 of the United States Code. The director may
3 seek waivers for any or all home- and community-based services
4 approvable under Section 1396n of Title 42 of the United States
5 Code. Coverage for those services shall be limited by the terms,
6 conditions, and duration of the federal waivers.

7 (u) Comprehensive perinatal services, as provided through an
8 agreement with a health care provider designated in Section
9 14134.5 and meeting the standards developed by the department
10 pursuant to Section 14134.5, subject to utilization controls.

11 The department shall seek any federal waivers necessary to
12 implement the provisions of this subdivision. The provisions for
13 which appropriate federal waivers cannot be obtained shall not be
14 implemented. Provisions for which waivers are obtained or for
15 which waivers are not required shall be implemented
16 notwithstanding any inability to obtain federal waivers for the
17 other provisions. No provision of this subdivision shall be
18 implemented unless matching funds from Subchapter XIX
19 (commencing with Section 1396) of Chapter 7 of Title 42 of the
20 United States Code are available.

21 (v) Early and periodic screening, diagnosis, and treatment for
22 any individual under 21 years of age is covered, consistent with
23 the requirements of Subchapter XIX (commencing with Section
24 1396) of Chapter 7 of Title 42 of the United States Code.

25 (w) Hospice service which is Medicare-certified hospice service
26 is covered, subject to utilization controls. Coverage shall be
27 available only to the extent that no additional net program costs
28 are incurred.

29 (x) When a claim for treatment provided to a beneficiary
30 includes both services which are authorized and reimbursable
31 under this chapter, and services which are not reimbursable under
32 this chapter, that portion of the claim for the treatment and services
33 authorized and reimbursable under this chapter shall be payable.

34 (y) Home- and community-based services approved by the
35 United States Department of Health and Human Services for
36 beneficiaries with a diagnosis of AIDS or ARC, who require
37 intermediate care or a higher level of care.

38 Services provided pursuant to a waiver obtained from the
39 Secretary of the United States Department of Health and Human
40 Services pursuant to this subdivision, and which are not otherwise

1 included in the Medi-Cal schedule of benefits, shall be available
2 only to the extent that federal financial participation for these
3 services is available in accordance with the waiver, and subject to
4 the terms, conditions, and duration of the waiver. These services
5 shall be provided to individual beneficiaries in accordance with
6 the client's needs as identified in the plan of care, and subject to
7 medical necessity and applicable utilization control.

8 The director may under this section contract with organizations
9 qualified to provide, directly or by subcontract, services provided
10 for in this subdivision to eligible beneficiaries. Contracts or
11 agreements entered into pursuant to this division shall not be
12 subject to the Public Contract Code.

13 (z) Respiratory care when provided in organized health care
14 systems as defined in Section 3701 of the Business and Professions
15 Code, and as an in-home medical service as outlined in subdivision
16 (s).

17 (aa) (1) There is hereby established in the department, a
18 program to provide comprehensive clinical family planning
19 services to any person who has a family income at or below 200
20 percent of the federal poverty level, as revised annually, and who
21 is eligible to receive these services pursuant to the waiver identified
22 in paragraph (2). This program shall be known as the Family
23 Planning, Access, Care, and Treatment (Family PACT) Program.

24 (2) The department shall seek a waiver in accordance with
25 Section 1315 of Title 42 of the United States Code, or a state plan
26 amendment adopted in accordance with Section
27 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States
28 Code, which was added to Section 1396a of Title 42 of the United
29 States Code by Section 2303(a)(2) of the federal Patient Protection
30 and Affordable Care Act (PPACA) (Public Law 111-148), for a
31 program to provide comprehensive clinical family planning
32 services as described in paragraph (8). Under the waiver, the
33 program shall be operated only in accordance with the waiver and
34 the statutes and regulations in paragraph (4) and subject to the
35 terms, conditions, and duration of the waiver. Under the state plan
36 amendment, which shall replace the waiver and shall be known as
37 the Family PACT successor state plan amendment, the program
38 shall be operated only in accordance with this subdivision and the
39 statutes and regulations in paragraph (4). The state shall use the
40 standards and processes imposed by the state on January 1, 2007,

1 including the application of an eligibility discount factor to the
2 extent required by the federal Centers for Medicare and Medicaid
3 Services, for purposes of determining eligibility as permitted under
4 Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United
5 States Code. To the extent that federal financial participation is
6 available, the program shall continue to conduct education,
7 outreach, enrollment, service delivery, and evaluation services as
8 specified under the waiver. The services shall be provided under
9 the program only if the waiver and, when applicable, the successor
10 state plan amendment are approved by the federal Centers for
11 Medicare and Medicaid Services and only to the extent that federal
12 financial participation is available for the services. Nothing in this
13 section shall prohibit the department from seeking the Family
14 PACT successor state plan amendment during the operation of the
15 waiver.

16 (3) Solely for the purposes of the waiver or Family PACT
17 successor state plan amendment and notwithstanding any other
18 provision of law, the collection and use of an individual's social
19 security number shall be necessary only to the extent required by
20 federal law.

21 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,
22 and 24013, and any regulations adopted under these statutes shall
23 apply to the program provided for under this subdivision. No other
24 provision of law under the Medi-Cal program or the State-Only
25 Family Planning Program shall apply to the program provided for
26 under this subdivision.

27 (5) Notwithstanding Chapter 3.5 (commencing with Section
28 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
29 the department may implement, without taking regulatory action,
30 the provisions of the waiver after its approval by the federal Health
31 Care Financing Administration and the provisions of this section
32 by means of an all-county letter or similar instruction to providers.
33 Thereafter, the department shall adopt regulations to implement
34 this section and the approved waiver in accordance with the
35 requirements of Chapter 3.5 (commencing with Section 11340) of
36 Part 1 of Division 3 of Title 2 of the Government Code. Beginning
37 six months after the effective date of the act adding this
38 subdivision, the department shall provide a status report to the
39 Legislature on a semiannual basis until regulations have been
40 adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, “comprehensive clinical family planning services” means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that

1 is not incident to the diagnosis of pregnancy. Comprehensive
2 clinical family planning services shall be subject to utilization
3 control and include all of the following:

4 (A) Family planning related services and male and female
5 sterilization. Family planning services for men and women shall
6 include emergency services and services for complications directly
7 related to the contraceptive method, federal Food and Drug
8 Administration approved contraceptive drugs, devices, and
9 supplies, and followup, consultation, and referral services, as
10 indicated, which may require treatment authorization requests.

11 (B) All United States Department of Agriculture, federal Food
12 and Drug Administration approved contraceptive drugs, devices,
13 and supplies that are in keeping with current standards of practice
14 and from which the individual may choose.

15 (C) Culturally and linguistically appropriate health education
16 and counseling services, including informed consent, that include
17 all of the following:

18 (i) Psychosocial and medical aspects of contraception.

19 (ii) Sexuality.

20 (iii) Fertility.

21 (iv) Pregnancy.

22 (v) Parenthood.

23 (vi) Infertility.

24 (vii) Reproductive health care.

25 (viii) Preconception and nutrition counseling.

26 (ix) Prevention and treatment of sexually transmitted infection.

27 (x) Use of contraceptive methods, federal Food and Drug
28 Administration approved contraceptive drugs, devices, and
29 supplies.

30 (xi) Possible contraceptive consequences and followup.

31 (xii) Interpersonal communication and negotiation of
32 relationships to assist individuals and couples in effective
33 contraceptive method use and planning families.

34 (D) A comprehensive health history, updated at the next periodic
35 visit (between 11 and 24 months after initial examination) that
36 includes a complete obstetrical history, gynecological history,
37 contraceptive history, personal medical history, health risk factors,
38 and family health history, including genetic or hereditary
39 conditions.

1 (E) A complete physical examination on initial and subsequent
2 periodic visits.

3 (F) Services, drugs, devices, and supplies deemed by the federal
4 Centers for Medicare and Medicaid Services to be appropriate for
5 inclusion in the program.

6 (9) In order to maximize the availability of federal financial
7 participation under this subdivision, the director shall have the
8 discretion to implement the Family PACT successor state plan
9 amendment retroactively to July 1, 2010.

10 (ab) (1) Purchase of prescribed enteral ~~formulae~~ nutrition
11 products is covered, subject to the Medi-Cal list of enteral ~~formulae~~
12 nutrition products and utilization controls.

13 (2) *Purchase of enteral nutrition products is limited to those*
14 *products to be administered through a feeding tube, including, but*
15 *not limited to, a gastric, nasogastric, or jejunostomy tube.*
16 *Beneficiaries under the Early and Periodic Screening, Diagnosis,*
17 *and Treatment Program shall be exempt from this paragraph.*

18 (3) *Notwithstanding paragraph (2), the department may deem*
19 *an enteral nutrition product, not administered through a feeding*
20 *tube, including, but not limited to, a gastric, nasogastric, or*
21 *jejunostomy tube, a benefit for patients with diagnoses, including,*
22 *but not limited to, malabsorption and inborn errors of metabolism,*
23 *if the product has been shown to be neither investigational nor*
24 *experimental when used as part of a therapeutic regimen to prevent*
25 *serious disability or death.*

26 (4) *Notwithstanding Chapter 3.5 (commencing with Section*
27 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
28 *the department may implement the amendments to this subdivision*
29 *made by the act that added this paragraph by means of all-county*
30 *letters, provider bulletins, or similar instructions, without taking*
31 *regulatory action.*

32 (5) *The amendments made to this subdivision by the act that*
33 *added this paragraph shall be implemented June 1, 2011, or on*
34 *the first day of the first calendar month following 60 days after*
35 *the date the department secures all necessary federal approvals*
36 *to implement this section, whichever is later.*

37 (ac) Diabetic testing supplies are covered when provided by a
38 pharmacy, subject to utilization controls.

39 SEC. 101.2. *Section 14134 of the Welfare and Institutions Code*
40 *is amended to read:*

1 14134. (a) Except for any prescription, refill, visit, service,
2 device, or item for which the program's payment is ten dollars
3 (\$10) or less, in which case no copayment shall be required, a
4 recipient of services under this chapter shall be required to make
5 copayments not to exceed the maximum permitted under federal
6 regulations or federal waivers as follows:

7 ~~(a)~~

8 (1) Copayment of five dollars (\$5) shall be made for
9 nonemergency services received in an emergency room. For the
10 purposes of this section, "nonemergency services" means any
11 services not required for the alleviation of severe pain or the
12 immediate diagnosis and treatment of severe medical conditions
13 which, if not immediately diagnosed and treated, would lead to
14 disability or death.

15 ~~(b)~~

16 (2) Copayment of one dollar (\$1) shall be made for each drug
17 prescription or refill.

18 ~~(c)~~

19 (3) Copayment of one dollar (\$1) shall be made for each visit
20 for services under subdivisions (a) and (h) of Section 14132.

21 ~~(d)~~

22 (4) The copayment amounts set forth in ~~subdivisions (a), (b),~~
23 ~~and (c) paragraphs (1), (2), and (3)~~ may be collected and retained
24 or waived by the provider.

25 ~~(e)~~

26 (5) The department shall not reduce the reimbursement otherwise
27 due to providers as a result of the copayment. The copayment
28 amounts shall be in addition to any reimbursement otherwise due
29 the provider for services rendered under this program.

30 ~~(f)~~

31 (6) This section does not apply to emergency services, family
32 planning services, or to any services received by:

33 ~~(1)~~

34 (A) Any child in AFDC-Foster Care, as defined in Section
35 11400.

36 ~~(2)~~

37 (B) Any person who is an inpatient in a health facility, as defined
38 in Section 1250 of the Health and Safety Code.

39 ~~(3)~~

40 (C) Any person 18 years of age or under.

1 ~~(4)~~

2 (D) Any woman receiving perinatal care.

3 ~~(g) Subdivision (b)~~

4 (7) Paragraph (2) does not apply to any person 65 years of age
5 or over.

6 ~~(h)~~

7 (8) A provider of service shall not deny care or services to an
8 individual solely because of that person's inability to copay under
9 this section. An individual shall, however, remain liable to the
10 provider for any copayment amount owed.

11 ~~(i)~~

12 (9) The department shall seek any federal waivers necessary to
13 implement this section. The provisions for which appropriate
14 federal waivers cannot be obtained shall not be implemented, but
15 provisions for which waivers are either obtained or found to be
16 unnecessary shall be unaffected by the inability to obtain federal
17 waivers for the other provisions.

18 ~~(j)~~

19 (10) The director shall adopt any regulations necessary to
20 implement this section as emergency regulations in accordance
21 with Chapter 3.5 (commencing with Section 11340) of Part 1 of
22 Division 3 of Title 2 of the Government Code. The adoption of
23 the regulations shall be deemed to be an emergency and necessary
24 for the immediate preservation of the public peace, health and
25 safety, or general welfare. The director shall transmit these
26 emergency regulations directly to the Secretary of State for filing
27 and the regulations shall become effective immediately upon filing.
28 Upon completion of the formal regulation adoption process and
29 prior to the expiration of the 120 day duration period of emergency
30 regulations, the director shall transmit directly to the Secretary of
31 State for filing the adopted regulations, the rulemaking file, and
32 the certification of compliance as required by subdivision (e) of
33 Section 11346.1 of the Government Code.

34 (b) *This section shall become inoperative on the implementation*
35 *date for copayments stated in the declaration executed by the*
36 *director pursuant to Section 14134 as added by Section 101.5 of*
37 *the act that added this subdivision, and is repealed on January 1*
38 *of the following year.*

39 SEC. 101.5. Section 14134 is added to the Welfare and
40 Institutions Code, to read:

1 14134. (a) *The Legislature finds and declares all of the*
2 *following:*

3 (1) *Costs within the Medi-Cal program continue to grow due*
4 *to the rising cost of providing health care throughout the state and*
5 *also due to increases in enrollment, which are more pronounced*
6 *during difficult economic times.*

7 (2) *In order to minimize the need for drastically cutting*
8 *enrollment standards or benefits or imposing further reductions*
9 *on Medi-Cal providers during times of economic crisis, it is crucial*
10 *to find areas within the program where beneficiaries can share*
11 *responsibility for utilization of health care, whether they are*
12 *participating in the fee-for-service or the managed care model of*
13 *service delivery.*

14 (3) *The establishment of cost-sharing obligations within the*
15 *Medi-Cal program is complex and is subject to close supervision*
16 *by the United States Department of Health and Human Services.*

17 (4) *As the single state agency for Medicaid in California, the*
18 *State Department of Health Care Services has unique expertise*
19 *that can inform decisions that set or adjust cost sharing*
20 *responsibilities for Medi-Cal beneficiaries receiving health care*
21 *services.*

22 (b) *Therefore, it is the intent of the Legislature for the*
23 *department to obtain federal approval to implement cost-sharing*
24 *for Medi-Cal beneficiaries and permit providers to require that*
25 *individuals meet their cost-sharing obligation prior to receiving*
26 *care or services.*

27 (c) *A Medi-Cal beneficiary shall be required to make*
28 *copayments as described in this section. These copayments*
29 *represent a contribution toward the rate of payment made to*
30 *providers of Medi-Cal services and shall be as follows:*

31 (1) *Copayment of up to fifty dollars (\$50) shall be made for*
32 *nonemergency services received in an emergency room. For the*
33 *purposes of this section, “nonemergency services” means services*
34 *not required for the alleviation of severe pain or the immediate*
35 *diagnosis and treatment of unforeseen medical conditions that, if*
36 *not immediately diagnosed and treated, would lead to disability*
37 *or death.*

38 (2) *Copayment of up to fifty dollars (\$50) shall be made for*
39 *emergency services received in an emergency room. For purposes*
40 *of this section, “emergency services” means services required for*

1 *the alleviation of severe pain or the immediate diagnosis and*
2 *treatment of unforeseen medical conditions that, if not immediately*
3 *diagnosed and treated, would lead to disability or death.*

4 (3) *Copayment of up to one hundred dollars (\$100) shall be*
5 *made for each hospital inpatient day, up to a maximum of two*
6 *hundred dollars (\$200) per admission.*

7 (4) *Copayment of up to three dollars (\$3) shall be made for*
8 *each preferred drug prescription or refill. A copayment of up to*
9 *five dollars (\$5) shall be made for each nonpreferred drug*
10 *prescription or refill. Except as provided in subdivision (g),*
11 *“preferred drug” shall have the same meaning as in Section 1916A*
12 *of the Social Security Act (42 U.S.C. Sec. 1396o-1).*

13 (5) *Copayment of up to five dollars (\$5) shall be made for each*
14 *visit for services under subdivision (a) of Section 14132 and for*
15 *dental services received on an outpatient basis provided as a*
16 *Medi-Cal benefit pursuant to this chapter or Chapter 8*
17 *(commencing with Section 14200), as applicable.*

18 (6) *This section does not apply to services provided pursuant*
19 *to subdivision (aa) of Section 14132.*

20 (d) *The copayments established pursuant to subdivision (c) shall*
21 *be set by the department, at the maximum amount provided for in*
22 *the applicable paragraph, except that each copayment amount*
23 *shall not exceed the maximum amount allowable pursuant to the*
24 *state plan amendments or other federal approvals.*

25 (e) *The copayment amounts set forth in subdivision (c) may be*
26 *collected and retained or waived by the provider. The department*
27 *shall deduct the amount of the copayment from the payment the*
28 *department makes to the provider whether retained, waived, or*
29 *not collected by the provider.*

30 (f) *Notwithstanding any other provision of law, and only to the*
31 *extent allowed pursuant to federal law, a provider of service has*
32 *no obligation to provide services to a Medi-Cal beneficiary who*
33 *does not, at the point of service, pay the copayment assessed*
34 *pursuant to this section. If the provider provides services without*
35 *collecting the copayment, and has not waived the copayment, the*
36 *provider may hold the beneficiary liable for the copayment amount*
37 *owed.*

38 (g) (1) *Notwithstanding any other provision of law, except as*
39 *described in paragraph (2), this section shall apply to Medi-Cal*
40 *beneficiaries enrolled in a health plan contracting with the*

1 department pursuant to this chapter or Chapter 8 (commencing
2 with Section 14200), except for Senior Care Action Network or
3 AIDS Healthcare Foundation. To the extent permitted by federal
4 law and pursuant to any federal waivers or state plan adjustments
5 obtained, a managed care health plan may establish a lower
6 copayment or no copayment.

7 (2) For the purpose of paragraph (4) of subdivision (c),
8 copayments assessed against a beneficiary who receives Medi-Cal
9 services through a health plan described in paragraph (1) shall
10 be based on the plan's designation of a drug as preferred or
11 nonpreferred.

12 (3) To the extent provided by federal law, capitation payments
13 shall be calculated on an actuarial basis as if copayments
14 described in this section were collected.

15 (h) This section shall be implemented only to the extent that
16 federal financial participation is available. The department shall
17 seek and obtain any federal waivers or state plan amendments
18 necessary to implement this section. The provisions for which
19 appropriate federal waivers or state plan amendments cannot be
20 obtained shall not be implemented, but provisions for which
21 waivers or state plan amendments are either obtained or found to
22 be unnecessary shall be unaffected by the inability to obtain federal
23 waivers or state plan amendments for the other provisions.

24 (i) Notwithstanding Chapter 3.5 (commencing with Section
25 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
26 the department may implement, interpret, or make specific this
27 section by means of all-county letters, all-plan letters, provider
28 bulletins, or similar instructions, without taking further regulatory
29 actions.

30 (j) (1) This section shall become operative on the date that the
31 act adding this section is effective, but shall not be implemented
32 until the date in the declaration executed by the director pursuant
33 to paragraph (2). In no event shall the director set an
34 implementation date prior to the date federal approval is received.

35 (2) The director shall execute a declaration that states the date
36 that implementation of the copayments described in this section
37 will commence and shall post the declaration on the department's
38 Internet Web site and provide a copy of the declaration to the
39 Chair of the Joint Legislative Budget Committee, the Chief Clerk

1 of the Assembly, the Secretary of the Senate, the Office of the
2 Legislative Counsel, and the Secretary of State.

3 SEC. 101.7. Section 14134.1 of the Welfare and Institutions
4 Code is amended to read:

5 14134.1. (a) Except as provided in paragraph (2) of
6 subdivision ~~(b)~~ (a) of Section 14134, no provider under this chapter
7 may deny care or services to an individual eligible for ~~such~~ care
8 or services under this chapter ~~on account~~ because of the
9 individual's inability to pay a copayment, as defined in Section
10 14134. The requirements of this section shall not extinguish the
11 liability of the individual to whom the care or services were
12 furnished for payment of the copayment.

13 (b) Notwithstanding Chapter 3.5 (commencing with Section
14 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
15 the department may implement, interpret, or make specific this
16 section by means of all-county letters, provider bulletins, or similar
17 instructions, without taking further regulatory action.

18 (c) This section shall become inoperative on the implementation
19 date for copayments stated in the declaration executed by the
20 director pursuant to Section 14134 as added by Section 101.5 of
21 the act that added this subdivision, and is repealed on January 1
22 of the following year.

23 SEC. 102. Section 14154 of the Welfare and Institutions Code
24 is amended to read:

25 14154. (a) (1) The department shall establish and maintain a
26 plan whereby costs for county administration of the determination
27 of eligibility for benefits under this chapter will be effectively
28 controlled within the amounts annually appropriated for that
29 administration. The plan, to be known as the County Administrative
30 Cost Control Plan, shall establish standards and performance
31 criteria, including workload, productivity, and support services
32 standards, to which counties shall adhere. The plan shall include
33 standards for controlling eligibility determination costs that are
34 incurred by performing eligibility determinations at county
35 hospitals, or that are incurred due to the outstationing of any other
36 eligibility function. Except as provided in Section 14154.15,
37 reimbursement to a county for outstationed eligibility functions
38 shall be based solely on productivity standards applied to that
39 county's welfare department office.

40 (2) (A) The plan shall delineate both of the following:

1 (i) The process for determining county administration base costs,
2 which include salaries and benefits, support costs, and staff
3 development.

4 (ii) The process for determining funding for caseload changes,
5 cost-of-living adjustments, and program and other changes.

6 (B) The annual county budget survey document utilized under
7 the plan shall be constructed to enable the counties to provide
8 sufficient detail to the department to support their budget requests.

9 (3) The plan shall be part of a single state plan, jointly developed
10 by the department and the State Department of Social Services, in
11 conjunction with the counties, for administrative cost control for
12 the California Work Opportunity and Responsibility to Kids
13 (CalWORKs), ~~Food Stamp~~ *CalFresh*, and Medical Assistance
14 (Medi-Cal) programs. Allocations shall be made to each county
15 and shall be limited by and determined based upon the County
16 Administrative Cost Control Plan. In administering the plan to
17 control county administrative costs, the department shall not
18 allocate state funds to cover county cost overruns that result from
19 county failure to meet requirements of the plan. The department
20 and the State Department of Social Services shall budget,
21 administer, and allocate state funds for county administration in a
22 uniform and consistent manner.

23 (4) The department and county welfare departments shall
24 develop procedures to ensure the data clarity, consistency, and
25 reliability of information contained in the county budget survey
26 document submitted by counties to the department. These
27 procedures shall include the format of the county budget survey
28 document and process, data submittal and its documentation, and
29 the use of the county budget survey documents for the development
30 of determining county administration costs. Communication
31 between the department and the county welfare departments shall
32 be ongoing as needed regarding the content of the county budget
33 surveys and any potential issues to ensure the information is
34 complete and well understood by involved parties. Any changes
35 developed pursuant to this section shall be incorporated within the
36 state's annual budget process by no later than the 2011–12 fiscal
37 year.

38 (5) The department shall provide a clear narrative description
39 along with fiscal detail in the Medi-Cal estimate package, submitted
40 to the Legislature in January and May of each year, of each

1 component of the county administrative funding for the Medi-Cal
2 program. This shall describe how the information obtained from
3 the county budget survey documents was utilized and, where
4 applicable, modified and the rationale for the changes.

5 (b) Nothing in this section, Section 15204.5, or Section 18906
6 shall be construed so as to limit the administrative or budgetary
7 responsibilities of the department in a manner that would violate
8 Section 14100.1, and thereby jeopardize federal financial
9 participation under the Medi-Cal program.

10 (c) (1) The Legislature finds and declares that in order for
11 counties to do the work that is expected of them, it is necessary
12 that they receive adequate funding, including adjustments for
13 reasonable annual cost-of-doing-business increases. The Legislature
14 further finds and declares that linking appropriate funding for
15 county Medi-Cal administrative operations, including annual
16 cost-of-doing-business adjustments, with performance standards
17 will give counties the incentive to meet the performance standards
18 and enable them to continue to do the work they do on behalf of
19 the state. It is therefore the Legislature's intent to provide
20 appropriate funding to the counties for the effective administration
21 of the Medi-Cal program at the local level to ensure that counties
22 can reasonably meet the purposes of the performance measures as
23 contained in this section.

24 (2) It is the intent of the Legislature to not appropriate funds for
25 the cost-of-doing-business adjustment for the 2008–09, 2009–10,
26 ~~and~~ 2010–11, *and 2011–12* fiscal years.

27 (d) The department is responsible for the Medi-Cal program in
28 accordance with state and federal law. A county shall determine
29 Medi-Cal eligibility in accordance with state and federal law. If
30 in the course of its duties the department becomes aware of
31 accuracy problems in any county, the department shall, within
32 available resources, provide training and technical assistance as
33 appropriate. Nothing in this section shall be interpreted to eliminate
34 any remedy otherwise available to the department to enforce
35 accurate county administration of the program. In administering
36 the Medi-Cal eligibility process, each county shall meet the
37 following performance standards each fiscal year:

38 (1) Complete eligibility determinations as follows:

39 (A) Ninety percent of the general applications without applicant
40 errors and are complete shall be completed within 45 days.

1 (B) Ninety percent of the applications for Medi-Cal based on
2 disability shall be completed within 90 days, excluding delays by
3 the state.

4 (2) (A) The department shall establish best-practice guidelines
5 for expedited enrollment of newborns into the Medi-Cal program,
6 preferably with the goal of enrolling newborns within 10 days after
7 the county is informed of the birth. The department, in consultation
8 with counties and other stakeholders, shall work to develop a
9 process for expediting enrollment for all newborns, including those
10 born to mothers receiving CalWORKs assistance.

11 (B) Upon the development and implementation of the
12 best-practice guidelines and expedited processes, the department
13 and the counties may develop an expedited enrollment timeframe
14 for newborns that is separate from the standards for all other
15 applications, to the extent that the timeframe is consistent with
16 these guidelines and processes.

17 (C) Notwithstanding the rulemaking procedures of Chapter 3.5
18 (commencing with Section 11340) of Part 1 of Division 3 of Title
19 2 of the Government Code, the department may implement this
20 section by means of all-county letters or similar instructions,
21 without further regulatory action.

22 (3) Perform timely annual redeterminations, as follows:

23 (A) Ninety percent of the annual redetermination forms shall
24 be mailed to the recipient by the anniversary date.

25 (B) Ninety percent of the annual redeterminations shall be
26 completed within 60 days of the recipient's annual redetermination
27 date for those redeterminations based on forms that are complete
28 and have been returned to the county by the recipient in a timely
29 manner.

30 (C) Ninety percent of those annual redeterminations where the
31 redetermination form has not been returned to the county by the
32 recipient shall be completed by sending a notice of action to the
33 recipient within 45 days after the date the form was due to the
34 county.

35 (D) When a child is determined by the county to change from
36 no share of cost to a share of cost and the child meets the eligibility
37 criteria for the Healthy Families Program established under Section
38 12693.98 of the Insurance Code, the child shall be placed in the
39 Medi-Cal-to-Healthy Families Bridge Benefits Program, and these
40 cases shall be processed as follows:

1 (i) Ninety percent of the families of these children shall be sent
2 a notice informing them of the Healthy Families Program within
3 five working days from the determination of a share of cost.

4 (ii) Ninety percent of all annual redetermination forms for these
5 children shall be sent to the Healthy Families Program within five
6 working days from the determination of a share of cost if the parent
7 has given consent to send this information to the Healthy Families
8 Program.

9 (iii) Ninety percent of the families of these children placed in
10 the Medi-Cal-to-Healthy Families Bridge Benefits Program who
11 have not consented to sending the child's annual redetermination
12 form to the Healthy Families Program shall be sent a request,
13 within five working days of the determination of a share of cost,
14 to consent to send the information to the Healthy Families Program.

15 (E) Subparagraph (D) shall not be implemented until 60 days
16 after the Medi-Cal and Joint Medi-Cal and Healthy Families
17 applications and the Medi-Cal redetermination forms are revised
18 to allow the parent of a child to consent to forward the child's
19 information to the Healthy Families Program.

20 (e) The department shall develop procedures in collaboration
21 with the counties and stakeholder groups for determining county
22 review cycles, sampling methodology and procedures, and data
23 reporting.

24 (f) On January 1 of each year, each applicable county, as
25 determined by the department, shall report to the department on
26 the county's results in meeting the performance standards specified
27 in this section. The report shall be subject to verification by the
28 department. County reports shall be provided to the public upon
29 written request.

30 (g) If the department finds that a county is not in compliance
31 with one or more of the standards set forth in this section, the
32 county shall, within 60 days, submit a corrective action plan to the
33 department for approval. The corrective action plan shall, at a
34 minimum, include steps that the county shall take to improve its
35 performance on the standard or standards with which the county
36 is out of compliance. The plan shall establish interim benchmarks
37 for improvement that shall be expected to be met by the county in
38 order to avoid a sanction.

39 (h) (1) If a county does not meet the performance standards for
40 completing eligibility determinations and redeterminations as

1 specified in this section, the department may, at its sole discretion,
2 reduce the allocation of funds to that county in the following year
3 by 2 percent. Any funds so reduced may be restored by the
4 department if, in the determination of the department, sufficient
5 improvement has been made by the county in meeting the
6 performance standards during the year for which the funds were
7 reduced. If the county continues not to meet the performance
8 standards, the department may reduce the allocation by an
9 additional 2 percent for each year thereafter in which sufficient
10 improvement has not been made to meet the performance standards.

11 (2) No reduction of the allocation of funds to a county shall be
12 imposed pursuant to this subdivision for failure to meet
13 performance standards during any period of time in which the
14 cost-of-doing-business increase is suspended.

15 (i) The department shall develop procedures, in collaboration
16 with the counties and stakeholders, for developing instructions for
17 the performance standards established under subparagraph (D) of
18 paragraph (3) of subdivision (d), no later than September 1, 2005.

19 (j) No later than September 1, 2005, the department shall issue
20 a revised annual redetermination form to allow a parent to indicate
21 parental consent to forward the annual redetermination form to
22 the Healthy Families Program if the child is determined to have a
23 share of cost.

24 (k) The department, in coordination with the Managed Risk
25 Medical Insurance Board, shall streamline the method of providing
26 the Healthy Families Program with information necessary to
27 determine Healthy Families eligibility for a child who is receiving
28 services under the Medi-Cal-to-Healthy Families Bridge Benefits
29 Program.

30 *SEC. 103. Section 14301.11 of the Welfare and Institutions*
31 *Code is amended to read:*

32 14301.11. (a) The department shall use funds attributable to
33 the tax on Medi-Cal managed care plans imposed by Section 12201
34 of the Revenue and Taxation Code for the purpose specified in
35 paragraph (1) of subdivision (b) of Section 12201 of the Revenue
36 and Taxation Code.

37 (b) This section shall become inoperative on ~~July 1, 2011~~
38 ~~January 1, 2014~~, and, as of ~~January 1, 2012~~ *July 1, 2014*, is
39 repealed, unless a later enacted statute, that becomes operative on

1 or before ~~January 1, 2012~~ July 1, 2014, deletes or extends the dates
2 on which it becomes inoperative and is repealed.

3 *SEC. 104. Article 6 (commencing with Section 14589) is added*
4 *to Chapter 8.7 of Part 3 of Division 9 of the Welfare and*
5 *Institutions Code, to read:*

6
7 *Article 6. Cessation of Adult Day Health Care and Assistance*
8 *with Transition from Adult Day Health Care Services to Other*
9 *Services*

10
11 *14589. (a) The Legislature finds and declares the following:*

12 *(1) During times of economic crisis, it is crucial to find areas*
13 *within the program where efficiencies can be achieved while*
14 *continuing to provide community-based services that support*
15 *independence.*

16 *(2) Adult Day Health Care (ADHC) has been vulnerable to*
17 *fraud and, despite attempts to curtail and prevent fraud, including,*
18 *but not limited to, a moratorium on new facilities and onsite*
19 *treatment authorization request review, fraud continues in this*
20 *area.*

21 *(3) The state has added services and programs to enable*
22 *vulnerable populations to remain in the community, including, but*
23 *not limited to, the Money follows the Person project, California's*
24 *1115 Comprehensive Medi-Cal Demonstration Project Waiver: a*
25 *Bridge to Reform, and services and supports, including day*
26 *programs, provided under the Lanterman Act. It also continues to*
27 *explore opportunities to add additional services and programs to*
28 *help individuals remain in the community, including, but not limited*
29 *to, pilot projects to better meet the health care needs of individuals*
30 *dually eligible for both Medicare and Medicaid, and exploring the*
31 *Community First Choice Option as a Medi-Cal benefit.*

32 *(4) There are alternative services to meet the needs of Medi-Cal*
33 *beneficiaries utilizing ADHC, including in-home supportive*
34 *services, physical, occupational, and speech therapies,*
35 *nonemergency medical transportation, and home health services.*

36 *(b) Therefore, it is the intent of the Legislature for the*
37 *department to obtain federal approval to eliminate ADHC as an*
38 *optional Medi-Cal benefit.*

39 *14589.5. (a) Notwithstanding any other provision of law*
40 *related to the Medi-Cal program or to adult day health care, adult*

1 *day health care is excluded from coverage under the Medi-Cal*
2 *program.*

3 *(b) This section shall only be implemented to the extent permitted*
4 *by federal law.*

5 *(c) Notwithstanding Chapter 3.5 (commencing with Section*
6 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
7 *the department may implement the provisions of this section by*
8 *means of all-county letters, provider bulletins, or similar*
9 *instructions, without taking further regulatory action.*

10 *(d) This section shall be implemented on the first day of the first*
11 *calendar month following 90 days after the effective date of the*
12 *act that adds this section or on the first day of the first calendar*
13 *month following 60 days after the date the department secures all*
14 *necessary federal approvals to implement this section, whichever*
15 *is later.*

16 *14590. (a) As a result of the enactment of this article to*
17 *eliminate adult day health care as an optional benefit under the*
18 *Medi-Cal program, the department shall implement a short-term*
19 *program to fund organizations to assist individuals receiving*
20 *ADHC services to transition to other Medi-Cal services, social*
21 *services, and respite programs, or to provide social activities and*
22 *respite assistance for individuals who were receiving ADHC*
23 *services at the time the services were eliminated. The goal of this*
24 *funding is to minimize the risk of institutionalization by identifying*
25 *needed services available in the community and providing*
26 *beneficiaries assistance in accessing those services.*

27 *(b) To ensure a smooth transition, adult day health care centers*
28 *shall provide relevant participant information, including the most*
29 *recent copy of a participant's individual plan of care, to the*
30 *department. Final Medi-Cal payment to adult day health care*
31 *centers is contingent upon the provision of participants' individual*
32 *plan of care and all documentation supporting that individual plan*
33 *of care, including medical records, to the grantee. Failure to*
34 *provide documents under this section is grounds for a temporary*
35 *withhold of payment to the adult day health care center under the*
36 *process established pursuant to Section 14107.11.*

37 *(c) To implement this section, the department may contract with*
38 *public or private entities and utilize existing health care service*
39 *provider enrollment and payment mechanisms, including the*
40 *Medi-Cal program's fiscal intermediary. Contracts entered into*

1 for the purposes of implementing this article, including any
2 contract amendments, system changes pursuant to a change order,
3 and any project or system development notices, may be developed
4 using a competitive process established by the department and
5 shall be exempt from Chapter 5.6 (commencing with Section 11545)
6 of Part 1 of Division 3 of Title 2 of the Government Code, Article
7 4 (commencing with Section 19130) of Chapter 5 of Part 2 of
8 Division 5 of Title 2 of the Government Code, and the Public
9 Contract Code, and any associated policies, procedures, or
10 regulations under those provisions, and shall be exempt from
11 review or approval by any division of the Department of General
12 Services and the California Technology Agency. A contract may
13 provide for periodic advance payments for services to be
14 performed.

15 (d) Notwithstanding the rulemaking provisions of the
16 Administrative Procedure Act (Chapter 3.5 commencing with
17 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
18 Code), the department may implement this article through provider
19 bulletins or similar instructions without taking regulatory action.

20 (e) Implementation of the short-term program to assist
21 individuals receiving ADHC services to transition to other
22 Medi-Cal services, social services, and respite programs, or to
23 provide social activities and respite assistance for individuals who
24 were receiving ADHC services at the time the services were
25 eliminated, is subject to an appropriation in the annual Budget
26 Act.

27 SEC. 105. During the 2011–12 Regular Session of the
28 Legislature, legislation will be adopted to create a new program
29 called the Keeping Adults Free from Institutions (KAFI) program.
30 This program will provide a well-defined scope of services to
31 eligible beneficiaries who meet a high medical acuity standard
32 and are at significant risk of institutionalization in the absence of
33 such community-based services. It is the intent of the Legislature
34 that the program allow current recipients of Adult Day Health
35 Care (ADHC) services that meet certain high acuity measures to
36 immediately transition to KAFI services. As prescribed by
37 subsequent statute, the Department of Health Care Services shall
38 develop a federal waiver to maximize federal reimbursement for
39 the KAFI program to the extent permitted by federal law. The
40 Budget Act of 2011 includes funding for the KAFI program.

1 *SEC. 106. This act addresses the fiscal emergency declared*
2 *and reaffirmed by the Governor by proclamation on January 20,*
3 *2011, pursuant to subdivision (f) of Section 10 of Article IV of the*
4 *California Constitution.*

5 *SEC. 107. If the Commission on State Mandates determines*
6 *that this act contains costs mandated by the state, reimbursement*
7 *to local agencies and school districts for those costs shall be made*
8 *pursuant to Part 7 (commencing with Section 17500) of Division*
9 *4 of Title 2 of the Government Code.*

10 *SEC. 108. This act is an urgency statute necessary for the*
11 *immediate preservation of the public peace, health, or safety within*
12 *the meaning of Article IV of the Constitution and shall go into*
13 *immediate effect. The facts constituting the necessity are:*

14 *In order to make changes necessary for implementation of the*
15 *Budget Act of 2011, it is necessary that this act take effect*
16 *immediately.*

17 ~~SECTION 1. It is the intent of the Legislature to enact statutory~~
18 ~~changes relating to the Budget Act of 2011.~~